

ARTICLES

THE MEDICARE APPEALS SYSTEM FOR COVERAGE AND PAYMENT DISPUTES: ACHIEVING FAIRNESS IN A TIME OF CONSTRAINT

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INTRODUCTION

Beneficiaries of the Medicare program and the health care professions and institutions that serve these beneficiaries have seriously questioned the adequacy of the Medicare appeals system for disputes over the coverage of and payment for Medicare benefits. These concerns stem from two major developments. First, the prospective payment system for hospitals has wrought monumental changes throughout the

Medicare program adopted in 1983. These changes include an increased utilization of outpatient services by Medicare beneficiaries, a modification of the hospital payment appeals procedures, and an increase in the number and complexity of appeals regarding all types of Medicare benefits. The second development is the beneficiaries' and providers' continuing and profound dissatisfaction with certain aspects of the Medicare appeals system. In recent years, many Supreme Court and federal court decisions concerning the Medicare appeals system have raised basic questions about its fundamental fairness to beneficiaries and providers.

As a result of these and other developments, beneficiaries, provider groups, and Congress have become more concerned about problems with Medicare appeals and more interested in considering reforms. Indeed, the House Ways and Means Committee acknowledged the need for a thorough review of the Medicare appeals system.¹ In addition, in the Omnibus Budget Reconciliation Act of 1986, Congress made several important reforms to the Medicare appeals system in response to some of these concerns.²

This study of the Medicare appeals system analyzes the processes available for beneficiaries and hospitals to appeal coverage and payment determinations under Part A and Part B of the Medicare program. The analysis reflects comments, concerns and observations of government officials, congressional staffs, and interest group representatives and their counsel.

The first chapter explains the Medicare program and touches briefly on some of the program's monumental accomplishments. The second chapter describes the growing problem of the escalating costs of providing services to beneficiaries. This problem has had a dispositive influence on the policies and conduct of the Department of Health and Human Services (HHS) and the Health Care Financing Administra-

1. H.R. REP. NO. 241, 99th Cong., 1st Sess. 45-46 (1985). In its report on the Consolidate Omnibus Budget Reconciliation Act of 1985, the report stated:

It has been thirteen years since this Committee has looked substantively at Medicare's [sic] appeals procedure. Since that time the Medicare program has undergone major changes. Inpatient hospital services that were reimbursed on a cost basis are now mostly subject to the prospective payment system. An increasing amount of services once provided only on an inpatient basis are now being provided in ambulatory settings. As a result of these current changes, the Committee believes that the current hearing and appeal procedure under Medicare needs to be reviewed.

Id.

2. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, Title IX, §§ 9301-9353, 100 Stat. 1874 (1986) [hereinafter Omnibus Budget Reconciliation Act of 1986] (codified as amended in scattered sections of 42 U.S.C.).

tion (HCFA) and in the administration of the Medicare program. The third chapter outlines the appeals procedures for payment and coverage disputes under Part A and Part B of the Medicare program. Chapters four, five, and six recount reported problems and concerns about the Medicare program and its appeals process in three areas: (1) program administration, (2) administrative hearing, and (3) the availability of administrative and judicial review.

Chapter seven contains the author's preliminary recommendations for changes in the Medicare appeals system. For some issues, however, it is necessary to obtain additional empirical information to understand the issues' full dimensions. Consequently, for these issues, Chapter seven makes suggestions for further study with a view toward making recommendations in the future. Further, this chapter proposes convening a conference of policy makers, affected interest groups, and scholars to discuss needed reforms in the Medicare appeals system. In proposing recommendations and making suggestions for further study and a national conference on Medicare appeals, the author is acutely aware that the Medicare program operates under unprecedented budgetary pressures and that curtailment of the administrative expenses associated with the Medicare program is in the best interest of this nation as well as, ultimately, beneficiaries and providers of the Medicare program.

During the fall of 1986 the Administrative Conference of the United States considered these recommendations. In December 1986 the Plenary Session of the Conference adopted most of these recommendations with some modifications.

I. THE MEDICARE PROGRAM

In 1965 Congress established the Medicare program to provide health insurance for the aged.³ At this time, the problem of access to quality health care services for the aged was especially severe. In 1963, although the aged had a greater risk of illness and far lower income than other population groups, only 56% had health insurance.⁴ When President Lyndon B. Johnson signed the Social Security Amendments

3. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 291 (1965) [hereinafter Social Security Amendments of 1965] (codified as amended at 42 U.S.C. §§ 1395-1395xx (Supp. II 1982)). At the same time Congress enacted the Medicaid program providing health insurance for certain low income individuals. 42 U.S.C. §§ 1396-1396p (Supp. II 1984).

4. Gornik, Greenberg, Eggers & Dobson, *Twenty Years of Medicare and Medicaid: Covered Populations, Use of Benefits, and Program Expenditures*, HEALTH CARE FIN. REV. 13, 14 (1985) [hereinafter *Twenty Years of Medicare and Medicaid*].

of 1965, his intent was for Medicare to remove financial barriers to quality health care services for the elderly.⁵

Enactment of the Medicare program was truly an extraordinary event. There was formidable ideological opposition, particularly from the medical profession, because of the fear of government control of medical practices.⁶ The hospital industry, however, was somewhat more receptive since the program would assure predictable payment for hospital services in an unprecedented manner.⁷ Nevertheless, the passage of the Medicare and Medicaid programs faced considerable obstacles, and was only possible because of the 1964 landslide victory of Democratic President Lyndon B. Johnson, his subsequent skillful management of the legislation, and the support of key congressmen.⁸

The political circumstances surrounding the passage of the Medicare and Medicaid programs help explain the programs' design. The initial House bill provided only for hospital insurance for the aged; supplementary medical insurance to cover physicians' services was added in an effort to broaden support for the bill among Republican congressmen.⁹ What finally emerged in the Social Security Amendments of 1965 were three distinct programs: the Medicare Hospital Insurance Program ("Part A"), the Medicare Supplementary Medical Insurance Program ("Part B"), and the Medicaid Program.¹⁰ Each of these pro-

5. Remarks at the Signing of the Medicare Bill, 2 PUB. PAPERS 811, 813 (July 30, 1965). President Johnson stated:

No longer will older Americans be denied the healing powers of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a life time so that they might enjoy dignity in later years.

Id.

6. See J. FEDER, *MEDICARE: THE POLITICS OF FEDERAL HOSPITAL INSURANCE* (1977); T. MARMOR, *THE POLITICS OF MEDICARE* (1973); R. MYERS, *MEDICARE* (1970); Cohen, *Reflections on the Enactment of Medicare and Medicaid*, HEALTH CARE FIN. REV. 3, 10 (1985).

7. See A. SOMERS & H. SOMERS, *MEDICARE AND THE HOSPITALS: ISSUES AND PROSPECTS* (1967) (discussing birth of Medicare system and prospects for its future).

8. Cohen, *supra* note 6.

9. See J. FEDER, *supra* note 6; T. MARMOR, *supra* note 6; Cohen, *supra* note 6, at 5-7. The Medicaid program evolved from a proposal of the American Medical Association that sought to build on existing Medical Assistance programs for the poor. Cohen, *supra* note 6, at 5-7.

10. Medicaid is a joint federal-state program providing hospital, physician and extensive nursing home services for persons who are on the Aid to Families with Dependent Children and Supplemental Security Income programs and, if the state elects, for persons who, but for income, meet the eligibility criteria for these categorical assistance programs. Social Security Act, § 1902(a)(10), 42 U.S.C. §§ 1396a(a)(10), 1396(b) (Supp II. 1984). Medicaid is financed out of federal revenues from general appropriations which match state expenditures for the Medicaid program. State programs must meet certain federal requirements to qualify for these federal matching funds. Social Security Act, §§ 1901, 1902(a), 42 U.S.C. §§ 1396, 1396(a) (Supp. II 1984). This

grams has different benefits, is financed and administered independently, and pays for services according to different methodologies.

A. *The Structure of the Medicare Program*

The Medicare program is fundamentally different from most other federal entitlement programs in that it does not provide cash benefits directly to its beneficiaries. Instead, the program relies on hospitals, other health care institutions, and physicians to calculate and provide benefits. This arrangement is consistent with the tradition in the American health care system that the determination of medical treatment is primarily the province of the medical profession.¹¹

Medicare, serving over 30 million individuals,¹² is the second largest

study does not address appeals under the Medicaid program which are handled primarily by the states.

11. Medicare has acknowledged this basic characteristic of the American health care system in its requirement that a physician, defined broadly under the statute to include osteopathic physicians, optometrists, podiatrists, dentists and chiropractors practicing within the scope of their license, Social Security Act, § 1861(r), 42 U.S.C. § 1395x(r) (Supp. II 1984), must certify that services provided to Medicare beneficiaries are reasonable and necessary for the treatment of illness. Social Security Act, §§ 1814(a), 1835(a), 42 U.S.C. §§ 1395g(a), 1395(a) (Supp. II 1984). Under state medical licensing laws, see American Hospital Association, *An Analysis of the Revised Medical Staff Standards of the Joint Commission on the Accreditation of Hospitals* (March 1984), as well as the prevailing accreditation standards for hospitals, see Joint Commission for the Accreditation of Hospitals, *Accreditation Manual for Hospitals* (1986) (focusing on a subject by subject analysis for hospital accreditation), only physicians, with their specialized knowledge and judgment acquired through years of medical education and training, can treat all types of human disease, admit patients, and once in the hospital, determine the hospital resources used for their care.

The Joint Commission for the Accreditation of Hospitals (JCAH) is a private accrediting body whose members are selected, for the most part, by the hospital industry and medical profession. A hospital that is accredited by the JCAH will be deemed to be in compliance with Medicare's conditions of participation for hospitals and eligible to provide hospital services to Medicare beneficiaries. Social Security Act, § 1865, 42 U.S.C. §§ 1395bb-1395x(e) (Supp. II 1984); 42 C.F.R. § 405(j) (1986). See generally Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulations of Health Care in the Public Interest*, 24 B.C.L. REV. 835 (1983) (discussing problems of high and rapidly rising cost of health care and effects of private regulation of health care). In 1984 the JCAH loosened the medical staff standards which delineated what type of health care professionals can serve on the medical staff of a hospital and have privileges to admit and treat patients in a hospital by authorizing medical staff membership and admitting privileges for some non-physician health care professionals within the scope of their license but with appropriate supervision by physicians. See Joint Commission for the Accreditation of Hospitals, *Accreditation Manual for Hospitals*, at 89-104; American Hospital Association, *An Analysis of the Revised Medical Staff Standards of the Joint Commission on Accreditation of Hospitals* (March 1984).

12. Levits, Lazenby, Waldo & Davidoff, *National Health Expenditures, 1984*, HEALTH CARE FIN. REV. 1, 23 (Fall 1985) [hereinafter *National Health Expenditures, 1984*].

federal entitlement program after the Social Security income maintenance program for the aged and disabled.¹³ Medicare comprised an estimated 7% of the federal budget for Fiscal Year 1986.¹⁴ Over 70% of Medicare expenditures in 1984 were for hospital services under Part A, and 23% were for physician and other outpatient services under Part B.¹⁵ Medicare is the largest single payer for hospital services in the nation, and in 1984 Medicare paid 28% of the nation's total bill for hospital care.¹⁶ Approximately 36% of the revenue received by the 5,800 community hospitals serving Medicare beneficiaries is generated by payments from the Medicare program. Consequently, many hospitals rely heavily on Medicare for the financial stability of their programs.¹⁷ Medicare is also the largest purchaser of physician and other outpatient services, and in 1984 Medicare paid approximately 25% of the nation's bill for these services.¹⁸

1. Administration

The Health Care Financing Administration, within the Department of Health and Human Services, administers the Medicare program. Initially, the Social Security Administration (SSA) administered the Medicare program. In 1977, however, the Carter Administration consolidated the Medicare and Medicaid programs into HCFA.¹⁹

HCFA contracts with private organizations to administer the claims of beneficiaries and the payment of providers under the Medicare program.²⁰ For Part A, these organizations are called "fiscal intermediaries," while for Part B they are referred to as "carriers." Despite the name difference, both of these organizations administer claims for coverage and payment. Congress adopted this unique program administration approach of contracting with private organizations because private insurance companies, such as Blue Cross and Blue Shield, al-

13. OFFICE OF MANAGEMENT AND BUDGET, BUDGET OF THE UNITED STATES, FY 1987, H.R. DOC. NO. 99-143, 99th Cong., 2d Sess. (1986) [hereinafter BUDGET OF THE UNITED STATES, FY 1987].

14. *Id.* at 5-109. This figure was derived by dividing estimated Medicare budget outlays for FY 1986 by total federal budget outlays for FY 1986.

15. *National Health Expenditures, 1984*, *supra* note 12, at 23.

16. *Id.* at 20; BUDGET OF THE UNITED STATES, FY 1987, *supra* note 13, at 5-108.

17. J. SCHWARTZ AND J. MARTIN, HOSPITAL INVOLVEMENT WITH MEDICARE AND MEDICAID: A STATISTICAL PROFILE (1983) (American Hospital Association, Office of Public Policy Analysis).

18. BUDGET OF THE UNITED STATES, FY 1987, *supra* note 13, at 5-108.

19. 42 Fed. Reg. 13,262 (1977).

20. *See* Social Security Act, §§ 1816, 1842, 42 U.S.C. §§ 1395h, 1395u (1982 & Supp. III 1985) (providing authorization to enter into agreements with agencies and carriers).

ready possessed the requisite expertise required for administering complex health insurance programs. Furthermore, the hospital industry lobbied for the arrangement as it allowed the hospitals to deal with familiar Blue Cross plans and insurance companies rather than with the federal government.²¹

The administration of the Medicare program is an enormous job, which includes determining the coverage of services and the amount of payment for such services for millions of beneficiary claims. In Fiscal Year 1987, HCFA estimates that the Medicare program will process 366 million claims — an increase of 33% over Fiscal Year 1986.²² HHS has requested \$957 million for the administration of the Medicare program in its Fiscal Year 1987 budget request, of which \$728 million is for essential claims processing services.²³ The determination of coverage and the payment for each claim is performed by the personnel of fiscal intermediaries, carriers, and now also peer review organizations (PRO's).²⁴ Congress delegated extraordinary adjudicative powers to these private organizations with respect to resolving appeals over coverage and payment issues arising under Part A and Part B of the Medicare program.

To provide the requisite guidance to fiscal intermediaries, insurance carriers, PRO's, hospitals, and other institutional providers, HCFA uses a massive compendium of multi-volume health insurance manuals for each individual organization and provider involved in the administration and provision of health care benefits to Medicare beneficiaries.²⁵

21. See S. LAW, *BLUE CROSS - WHAT WENT WRONG?* 31-50 (1976); H.R. REP. NO. 213, 89th Cong., 1st Sess. 45-47 (1965); S. REP. NO. 404, 89th Cong., 1st Sess. 52-54 (1965).

22. Department of Health and Human Services, *HHS Fiscal Year 1987 Budget Request* (Feb. 5, 1986) [hereinafter *HHS Fiscal Year 1987 Budget Request*].

23. *Id.*

24. Peer Review Organizations are physician-dominated organizations responsible for determining whether certain benefits provided to Medicare beneficiaries are medically necessary and provided in an appropriate setting. See *infra* notes 118-132 and accompanying text (describing establishment and role of PRO's in Medicare program).

25. These health insurance manuals include the following: Group Practice Prepayment Plan Manual (HIM-8); Hospital Manual (HIM-10); Home Health Agency Manual (HIM-11); Skilled Nursing Facility Manual (HIM-12); Medicare Intermediaries Manual (HIM-13); Medicare Carriers Manual (HIM-14); Provider Reimbursement Manual (HIM-15); Medicare Renal Dialysis Facility Manual (HIM-29); and PRO Manual. HCFA constantly updates these manuals through "transmittals." For directives without ongoing effect, HCFA uses program memoranda. The Program Memoranda series went into effect March 1985 and includes: Program Memoranda: Intermediaries; Program Memoranda: Carriers; Program Memoranda: Intermediaries/Carriers. This series replaced the former series of program directives called Intermediary Letters. 1 *MEDICARE & MEDICAID GUIDE* (CCH), at 523. There is also a comparable series for Peer Review Organizations.

In addition, HCFA publishes a specific manual on Medicare coverage issues listing what technologies, procedures, and services HHS includes as covered benefits under the Medicare program.²⁶ These manuals and other program directives are strictly interpretive and are not promulgated pursuant to the informal notice and comment rulemaking requirements of the Administrative Procedure Act.²⁷ As of September 1981, HCFA publishes rulings not previously published in the *Federal Register* in order to clarify points of statutory and regulatory interpretation.²⁸ HCFA has issued only twelve rulings since 1981.

2. Eligibility

All individuals who are eligible for the Social Security old age and disability insurance programs are eligible for Part A and Part B of the Medicare program.²⁹ Eligibility for these programs further extends to nearly all other elderly not covered by the Social Security program³⁰ and to certain other individuals with End Stage Renal Disease.³¹ Enrollment in both Part A and Part B of the Medicare program is voluntary.³² Furthermore, there is no cost to enroll in Part A.³³ To enroll in Part B, however, the eligible individual must pay monthly premiums.³⁴

HCFA gives each fiscal intermediary and carrier copies of these health insurance manuals and distributes manuals to providers and other organizations as their needs require. However, HCFA does not make these manuals generally available to the public or even to providers because of their large size, cost, and their need to be updated constantly. 42 C.F.R. § 401.112 (1986). Portions of these manuals that affect the public are distributed to local Social Security Administration offices. *Id.* §§ 401.130-132 Beneficiary advocacy groups, however, maintain that such distribution does not always occur in practice.

26. Health Care Financing Administration, *Medicare Coverage Issues Manual* HCFA-Pub. 6, reprinted in 4 MEDICARE & MEDICAID GUIDE (CCH) ¶ 27,201-27,221.

27. 5 U.S.C. § 553 (Supp. II 1984).

28. 42 C.F.R. § 401.108 (1986).

29. See Social Security Act, §§ 1811, 1836, 42 U.S.C. §§ 1395c, 1395o (Supp. III 1985) (defining eligibility requirements).

30. See Social Security Act, §§ 1818, 1836, 42 U.S.C. §§ 1395i-2, 1395o (1982 & Supp. III 1985) (defining eligibility requirements and benefits for unusual individuals).

31. See Social Security Act, § 1811, 42 U.S.C. § 1395c (1982) (allowing individuals or states to contract or provide health care protection).

32. See Social Security Act, § 1803, 42 U.S.C. § 1395b (1982 & Supp. III 1985) (allowing individuals or states to contract or provide health care protection).

33. See Social Security Act, § 1811, 42 U.S.C. § 1395c (1982 & Supp. III 1985) (providing eligibility requirements for coverage).

34. See Social Security Act, §§ 1839, 1840, 42 U.S.C. §§ 1395r, 1395s (1982 & Supp. III 1985) (describing payment of premiums). State Medicaid programs may pay Part B premiums for the elderly who also receive Medicaid benefits. An estimated 85% of the Medicaid aged have Part B insurance purchased by state Medicaid programs. *Twenty Years of Medicare and Medicaid*, *supra* note 4, at 29; see Social Security Act, §§ 1839, 1840, 1843, 42 U.S.C. §§ 1395r, 1395s (1982 & Supp. III 1985) (explaining premiums and payment of premiums).

About 97% of all eligible individuals have enrolled in Part B.³⁵

3. Benefits

Part A. The benefits provided under Part A, the hospital insurance component, include 90 days of basic hospitalization for each spell of illness.³⁶ Moreover, there is no limit on the number of hospital admissions which are granted coverage as long as there is only one admission in a single benefit period. A benefit period spans from the time of admission until 60 days after discharge.³⁷ Part A coverage also includes a stay of 100 days in a skilled nursing facility following a hospitalization,³⁸ an unlimited number of home health agency visits if the beneficiary is confined to home,³⁹ and some limited hospice services for patients who are terminally ill.⁴⁰ When patients avail themselves of the hospital benefit, they must pay a deductible amounting to the cost of the first day of the hospitalization, and in addition, some coinsurance is required after the 60th day of a hospital stay.⁴¹ Coinsurance is also required for skilled nursing services, but not for home health services.⁴²

Part B. The benefits provided under Part B, the supplementary medical insurance component, include physicians' services plus a wide vari-

35. *Twenty Years of Medicare and Medicaid*, *supra* note 4, at 14.

36. See Social Security Act, § 1812, 42 U.S.C. § 1395d (1982); 42 C.F.R. § 409.10-.27, 406.60-.69 (1986) (explaining hospitalization payment requirements).

37. In any benefit period, a beneficiary is entitled to 60 fully paid days of hospital care, subject only to the initial deductible amount. After 60 days, a beneficiary must pay a per diem coinsurance amount equal to one-fourth of the initial deductible. After 90 days, the per diem coinsurance amount doubles that of the amount for days 61 through 90. In addition, each day of hospital care in excess of 90 is subtracted from the beneficiary's 60 days of "lifetime reserve" which he may use only once. See Social Security Act, § 1813(a), 42 U.S.C. § 1395e(a) (1982) (delineating inpatient hospital care).

Covered benefits under Part A include nearly all services, except for luxuries, generally provided in a hospital stay, namely room and board in a semi-private room, nursing services, operating and recovery room costs, drugs and medical supplies furnished in the hospital, laboratory tests, radiological services billed by the hospital, rehabilitation services, and blood. See Social Security Act § 1861(b), 42 U.S.C. § 1395x(b) (1982) (defining inpatient hospital care).

38. Social Security Act, § 1812(a)(2)(A), 42 U.S.C. § 1395d(a)(2)(A) (Supp. II 1984); 42 C.F.R. §§ 409.30-.36 (1986).

39. Social Security Act, § 1861(m), 42 U.S.C. § 1395x(m) (1982). Home health services include: part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse; physical, occupational, or speech therapy; some medical supplies and durable medical equipment; and other items and services. To be eligible for home health services, the beneficiary must be "confined to home" and "in need of intermittent skilled nursing care." 42 C.F.R. § 409.42 (1986).

40. Social Security Act, § 1812(d), 42 U.S.C. § 1395d(d) (1982).

41. Social Security Act, § 1813, 42 U.S.C. § 1395e (1982).

42. Social Security Act, § 1813(a)(3), 42 U.S.C. § 1395e(a)(3) (1982).

ety of other medical services provided on an outpatient basis.⁴³ These include services provided in hospital outpatient departments and rural health clinics; outpatient surgery; diagnostic x-ray and laboratory services; rehabilitative services; physical, occupational, and speech therapy; and services ordered by a physician but performed by physicians' assistants and nurse practitioners. Part B also provides some home health services not covered under Part A.⁴⁴ Finally, an increasingly important and costly Part B benefit is the lease or purchase of durable medical equipment.⁴⁵ There is no limitation on the number of physicians' services which fall under Part B coverage.⁴⁶ Enrollees pay an annual deductible of \$75 and pay 20% coinsurance on most covered services incurred during the year.⁴⁷

4. Coverage

Coverage is an important concept in understanding Medicare benefits, particularly the disputes over benefits that arise between benefi-

43. See Social Security Act, § 1832, 42 U.S.C. § 1395k (1982 & Supp. III 1985) (defining scope of services and benefits).

44. Although the home health services covered by Part A and Part B are identical, there is a slight difference between the two programs concerning the definition of "home health agency." Under Part B, but not Part A, the term includes any agency or organization which is primarily for the care and treatment of mental diseases. Social Security Act, § 1861(o), 42 U.S.C. § 1395x(o) (1982).

45. See Social Security Act, § 1832, 42 U.S.C. § 1395k (1982 & Supp III 1985); 42 C.F.R. § 405.231(g) (1986) (defining generally scope of benefits).

46. See Social Security Act, § 1862(a)(1)(A), 42 U.S.C. 1395y(a)(1)(A) (1982 & Supp. III 1985) (allowing payment for any reasonable and necessary medical expense).

47. Social Security Act, § 1833(a),(b), 42 U.S.C. § 13952(a),(b) (1982). It should be emphasized that physicians and suppliers of durable medical equipment under Part B are not required to accept Medicare payment as payment in full for their services. Social Security Act, § 1842(b)(3)(B)(1), 42 U.S.C. § 1395u(b)(3)(B) (1982 & Supp. III 1985); see STAFF OF SPECIAL SENATE COMM. ON AGING, 98TH CONG., 2D SESS., MEDICARE: PAYING THE PHYSICIAN — HISTORY, ISSUES, AND OPTIONS 3 (Comm. Print 1984) [hereinafter MEDICARE: PAYING THE PHYSICIAN] (discussing physician payment procedures). Rather, they can bill Medicare patients directly for any amount they wish to charge and patients must then submit claims to the Medicare program for payment. A physician or supplier may accept assignment of a beneficiary's benefits but upon doing so relinquishes the right to bill the beneficiary for the difference between Medicare's payment and the full charge for the services. See Social Security Act, § 1842(b)(3)(B)(ii), 42 U.S.C. § 1395u(b)(3)(B)(ii) (1982 & Supp. III 1985) (permitting assignments of benefits). As will be discussed below, physicians and suppliers, until recently, have had little incentive to accept assignment. See *infra* notes 174-77 and accompanying text (discussing physician reimbursement reform measures under DEFRA). In 1985, because of payment reforms enacted by Congress, see *infra* notes 174-86 and accompanying text (discussing payment reforms under DEFRA (1984) and (COBRA 1985)), approximately 68.1% of physicians accepted assignment which was a marked increase over past years. Jencks & Dobson, *Strategies for Reforming Medicare's Physician Payments - Physician Diagnosis-Related Groups and Other Approaches*, 312 NEW ENG. J. MED. 1492 (1985).

ciaries, providers, and the Medicare program. In effect, coverage defines the type and the amount of health care benefits that the Medicare program will pay for as well as the conditions that must be met in order to receive payment. The Social Security Act specifies certain types of services that are expressly excluded from coverage under the Medicare program.⁴⁸ For both Part A and Part B, such services include physicals, immunizations, eyeglasses and hearing aids, personal comfort items, and cosmetic surgery.⁴⁹ One is entitled to coverage only if two conditions are met. First, the services rendered must not be covered by another public insurance program,⁵⁰ and, second, the services must be "reasonable and necessary" for the diagnosis and treatment of an illness or injury.⁵¹

The condition requiring that the services be reasonable and necessary for the treatment of an illness or injury generates most of the disputes over coverage and the bulk of appeals on coverage determinations under both Part A and Part B.⁵² Determinations of whether a service, procedure, or technology is "reasonable and necessary" and, therefore, a covered benefit under the Medicare program are made at two levels. The first level is a determination of whether a technology, procedure, or service should be covered as a matter of general policy. When questions of coverage are raised by intermediaries or carriers or identified by HCFA,⁵³ HCFA determines what new procedures and technologies will be covered Medicare benefits.⁵⁴ This determination, if it involves a

48. Social Security Act, § 1862, 42 U.S.C. § 1395y (1982 & Supp. III 1985); 42 C.F.R. §§ 403.310-323 (1986); see *Medicare Beneficiary Appeals Processes*, reprinted in Prospective Payment Assessment Commission, *Technical Appendixes to the Report and Recommendations to the Secretary*, U.S. Department of Health and Human Services, April 1, 1986, Appendix C, at 162, 165-66 [hereinafter *Technical Appendixes to ProPAC Report*] (acknowledging that Social Security Act excludes some medically necessary procedures).

49. 42 C.F.R. §§ 405.310-323 (1986).

50. Social Security Act, § 1862(a)(2)-(3), 42 U.S.C. § 1395y(a)(2)-(3) (Supp. III 1985); 42 C.F.R. §§ 405.322-325 (1986).

51. Social Security Act, § 1862(a)(1), 42 U.S.C. § 1395y(a)(1) (1982 & Supp. III 1985); 42 C.F.R. § 405.310(k) (1986).

52. *Technical Appendixes to ProPAC Report*, supra note 48, Appendix C, at 165-66.

53. See Banta, Ruby & Burns, *Using Coverage Policy to Certain Medicare Costs*, and Retting, *The Medicare Coverage Decision Process and Medical Technology*, reprinted in STAFF OF HOUSE COMM. ON WAYS AND MEANS, 98TH CONG., 2D SESS., PROCEEDINGS OF THE CONFERENCE ON THE FUTURE OF MEDICARE 129-48 (Comm. Print 1984); see also Ruby, Banta & Burns, *Medicare Coverage, Medical Costs, and Medical Technology*, 10 J. HEALTH POL. POL'Y AND L. 141 (1985).

54. See 52 Fed. Reg. 15560 (1987) (elaborating on HCFA procedures for making determinations requiring Medicare payment); see also Banta, Ruby & Burns, *Using Coverage Policy to Contain Medicare Costs*, STAFF OF HOUSE COMM. ON WAYS AND MEANS, 98TH CONG., 2D SESS., PROCEEDINGS OF THE CONFERENCE ON THE FUTURE OF

Medical question,⁵⁵ is done in consultation with a panel of HCFA physicians. If HCFA wants additional medical consultation, it may refer the question to the Office of Health and Technology in Public Health Service, which, in major questions, may solicit public comment and input through a notice in the *Federal Register* and conduct a full scale technology assessment of the item or procedure in question.⁵⁶ To date, the procedures for making these so called "national coverage determinations" have been relatively informal and have arguably not provided adequate opportunity for interested parties to have input into the coverage decision process.⁵⁷ In view of a recent study,⁵⁸ and the decision in a recent lawsuit which mandated the publication of the description of procedures in 1987,⁵⁹ HHS is now considering reforms in its procedures for making national coverage decisions.

The second level at which coverage decisions are made is the individual beneficiary level. The coverage determinations, in individual cases, require a decision based on medical criteria that establishes whether the benefit was either necessary and reasonable in a specific instance or provided in an appropriate setting. For hospital services under Part A, PRO's make the coverage determination.⁶⁰ For skilled nursing and home health services under Part A, fiscal intermediaries make the coverage determination. For all Part B services, however, carriers make this coverage determination.⁶¹ Under Part A, hospital and skilled nursing services are covered only on the condition that the care received was not "custodial."⁶² Due to the inherent uncertainty in these types of coverage decisions, Congress authorized the Secretary of HHS to waive a beneficiary's or provider's liability for services not covered on the basis of medical criteria if the beneficiary or provider did not know or

MEDICARE 129-148 (Comm. Print 1984) (explaining coverage decisionmaking process).

55. See 52 Fed. Reg. 15560, 15562 (1987) (describing HCFA analysis).

56. See 52 Fed. Reg. 15560 (1987) (outlining HCFA procedural analysis).

57. See Letter from John B. Reiss to Jeffrey S. Lubbers (Nov. 6, 1986); Letter from Ronald R. Kovener to Jeffrey S. Lubbers (Nov. 7, 1986); Letter from William A. Dombi to Deborah Ross (Oct. 28, 1986) (all discussing Draft Recommendations on the Medicare Appeals System).

58. See W. ROE, M. ANDERSON, J. GONG AND M. STRAUSS, A FORWARD PLAN FOR MEDICARE COVERAGE AND TECHNOLOGY ASSESSMENT (Department of Health and Human Services Contract Number 282-85-0062).

59. Jameson v. Bowen, No. V-F-83-547-REC (E.D. Cal.)

60. See *infra* notes 216-17 and accompanying text (explaining that Congress delegated decisionmaking authority to PRO's).

61. See *infra* notes 277-301 and accompanying text (explaining appeals process under Part B).

62. Social Security Act, § 1862(a)(9), 42 U.S.C. § 1395y(a)(9) (1982); see *Technical Appendixes to ProPAC Report*, *supra* note 48, Appendix C, at 165 (stating that HCFA or PRO's must determine what services constitute mere custodial use).

have reason to know that such services were not covered.⁶³

5. *Financing*

Part A of the Medicare program is financed by the Hospital Insurance Trust Fund, which in turn is funded through a mandatory Social Security payroll tax imposed on all wage earners.⁶⁴ Part B is financed by the Supplementary Medicare Insurance Trust Fund, which obtains funds from the collection of enrollees' premiums and by congressional appropriations.⁶⁵ The premiums comprise approximately 25% of the total Part B trust fund; the remaining 75% comes from congressional appropriations.⁶⁶

6. *Payment Methods*

It is important to appreciate that under the Medicare and Medicaid programs, Congress initially gave hospitals and physicians almost complete autonomy to structure both the payment methodology and payment levels. Former Secretary of the Department of Health, Education, and Welfare (HEW) Wilbur Cohen, a chief architect of the Medicare program, observed: "The ideological and political issues [surrounding payment methods and payment levels] were so dominating that they precluded consideration of peripheral issues such as reimbursement alternatives and efficiency options."⁶⁷ Indeed, the only constraints the Social Security Amendments of 1965 imposed on hospitals and physicians in setting their payment levels under the Medicare program was that the level be "reasonable" and the services provided be "necessary" for the treatment of illness or injury.⁶⁸ Since the inception of the Act, however, Congress and federal policy makers have been gravely concerned about payment methodologies employed under the Medicare program. As a result, they instituted major reforms in payment methodologies for acute care hospitals under Part A and are presently developing major reforms in payment methodologies for services under Part B.

63. Social Security Act, § 1879, 42 U.S.C. § 1395pp(a)(20) (1982); *see infra* notes 206-10 and accompanying text (describing hardships caused by retroactive determinations of noncoverage).

64. Social Security Act, § 1817, 42 U.S.C. § 1395i(a) (Supp. III 1985).

65. Social Security Act, § 1841, 42 U.S.C. § 1395t (1982).

66. *National Health Expenditures, 1984, supra* note 12, at 23, Table 9.

67. Cohen, *supra* note 6, at 5.

68. Social Security Act, § 1815, 42 U.S.C. § 1395 (Supp. III 1985).

B. The Medicare Program's Accomplishments

The Medicare program's accomplishments have been substantial, and this entitlement program, although costly, has clearly been a success. Between 1967 and 1983, Medicare beneficiaries increased their utilization of hospital, home health, and physician services.⁶⁹ Moreover, evidence exists that Medicare has played an important role in improving the health status of the elderly. For example, a two and one-half year increase in life expectancy has occurred among the aged since 1965. In addition, there has been a drop of 30% or more in the age-adjusted death rates for diseases such as heart disease, stroke, diabetes and pneumonia, all of which afflict the elderly.⁷⁰

The performance of the Medicare program, however, has been seriously deficient with regard to its cost. One particularly unfortunate aspect of the cost problem is its impact on beneficiaries. As a result of the Part A and Part B deductibles and coinsurance requirements, as well as the fact that physicians who do not accept assignment can bill patients directly for the difference between Medicare's payment and their full charge, Medicare beneficiaries are now responsible for 44% of their medical expenses. Presently, Medicare beneficiaries devote nearly the same proportion of their income to medical care as they did before the Medicare program.⁷¹

Perhaps the most serious long-term ramification of the cost problem is the financial insolvency that may occur to Part A and Part B of the Medicare program. Evidence suggests that if the Medicare program continues to provide benefits at its current levels and payment rates, the system may well be insolvent by the end of the century.⁷² One must recognize the underlying threat of insolvency when evaluating HHS,

69. *Twenty Years of Medicare and Medicaid*, *supra* note 4, at 35-41.

70. *What Medicaid and Medicare Did - and Did Not - Achieve*, Hospitals, Aug. 1, 1985, at 41-42 (interview with Karen Davis, Ph.D.).

71. Aiken & Bays, *Special Report: The Medicare Debate - Round One*, 311 NEW ENG. J. MED. 1190 (1981); see also STAFF OF HOUSE SELECT COMM. ON AGING, 96TH CONG., 2D SESS., *MEDICARE AFTER 15 YEARS: HAS IT BECOME A BROKEN PROMISE TO THE ELDERLY?* (Comm. Print 1980). On June 10, 1986, the House Ways and Means Committee held hearings on the problem of beneficiaries' costs associated with Part B physician services and proposed measures to correct this serious problem. See *Out-of-Pocket Costs for Physician Services: Hearings Before the Subcomm. on Health of the House Comm. on Ways and Means*, 99th Cong., 2d Sess. (1986).

72. See Ginsberg & Moon, *An Introduction to the Medicare Financing Problem*, reprinted in STAFF OF HOUSE COMM. ON WAYS AND MEANS, 98TH CONG., 2D SESS., *PROCEEDINGS OF THE CONFERENCE ON THE FUTURE OF MEDICARE 1, 4* (Comm. Print 1984); see also Svahn & Ross, *Social Security Amendments of 1983: Legislative History and Summary of Provisions*, Social Security Bull., July 1983, at 3; Mussey, *Actuarial Status of the HI and SMI Trust Funds*, Social Security Bull., June 1985, at 32.

HCFA, and HCFA fiscal intermediaries and carriers in the administration of the Medicare program and their handling of beneficiary and provider appeals.

II. THE COST CRISIS AND SEARCH FOR SOLUTIONS

A. *The Crisis*

Congress and HEW almost immediately recognized that the costs of the Medicare program would greatly exceed the initial Medicare cost projections.⁷³ These predictions proved correct, and total Medicare expenditures rose from \$4.6 billion in 1967 to \$62.9 billion in 1985.⁷⁴ During this period, Part A expenditures rose from \$3.4 billion to \$43.3 billion, and Part B expenditures rose from \$1.2 billion to \$19.7 billion.⁷⁵ The most serious problem, because of its relative size and severe inflation rate, was escalating hospital costs. As previously noted, expenditures for hospital services constitute about 70% of all Medicare expenditures.⁷⁶ These expenditures rose at an annual compound rate of 17.2% between 1967 and 1983.⁷⁷ In addition, during this period physician services, constituting 23% of Medicare expenditures,⁷⁸ rose at an annual compounded rate of 17.4%.⁷⁹ The annual compounded growth rate for skilled nursing facilities services, however, rose only 2.8%, while the rate for home health services rose 24.1%.⁸⁰

1. *Initial Payment Methodologies*

As previously noted, the initial payment methodologies were quite favorable to health care institutions under Part A and for services of physicians and suppliers under Part B. These methodologies were based on methodologies that conformed closely to provider billing and accounting practices. Until the enactment of the Social Security Amendments of 1983, Medicare paid all Part A providers an amount equal to the reasonable cost of covered services and, for the most part, it still

73. *Reimbursement Guidelines for Medicare: Hearings Before the Senate Comm. on Finance*, 89th Cong., 2d Sess. (1966).

74. *Twenty Years of Medicaid and Medicare*, *supra* note 4, at 42.

75. *Id.* at 43.

76. *See National Health Expenditures, 1984*, *supra* note 12; *see also supra* note 15 and accompanying text (noting that in 1984 over 70% of Medicare expenses were for hospital services under Part A).

77. *Twenty Years of Medicaid and Medicare*, *supra* note 4, at 43.

78. *See supra* note 15 and accompanying text (explaining that physicians' services constitute 23% of the periodical expenses).

79. *Twenty Years of Medicaid and Medicare*, *supra* note 4, at 43.

80. *Id.*

pays skilled nursing facilities and most home health facilities according to this payment methodology of retrospective cost reimbursement.⁸¹ Congress then delegated to the Secretary of HEW the responsibility of developing, through regulations, the definition of "reasonable cost."⁸² The reasonable cost to Part A providers must be accepted as full payment for a beneficiary's stay. Hospitals cannot charge the beneficiary any additional sums for covered benefits, even if the hospital's costs in providing the services exceeded Medicare's payment for those services.⁸³

The amount of payments made by Medicare to physicians under Part B has always been based on what the physician charges for his services. Payments, however, are limited to either the physician's customary charge for the same or similar services, the maximum prevailing charge for that service of all physicians in the area, or the amount actually charged by the physician.⁸⁴ Under the Medicare basic payment methodology for physicians' services, physicians are paid 80% of the reasonable charge for all covered services that they provide.⁸⁵ In most cases, the reasonable charge for a specific service is calculated as either the lowest of the physician's customary charge for the service, the prevailing charge for the service in that area, or the amount actually charged by the physician.⁸⁶ Each July, carriers update the customary charge of each individual physician and the prevailing charge of all physicians with comparable qualifications in the carrier's service area.⁸⁷

81. Social Security Act, 42 U.S.C. § 1395x(v) (1982 & Supp. III 1985). Under the retrospective cost reimbursement system, Medicare reimbursed direct costs, such as room, board and nursing care, that are directly related to patient care and generally pertain to services for which charges can be made. Medicare also paid indirect costs, i.e., those not directly attributable to patient care but incurred in the operation and administration of a hospital. Included among indirect costs are the major capital cost of providers, i.e., depreciation on a provider's plant buildings and equipment, interest on capital debt, lease expenses for capital assets, and, for proprietary providers only, a reasonable return on equity capital. *See id.* (discussing reasonable costs); *see also* 42 C.F.R. §§ 405.402-480 (1986) (stating criteria for determining reasonable charges in reimbursing hospital interns, residents, and physicians).

82. For skilled nursing facilities and home health agencies, the Medicare statute and regulations impose a limit on the total annual costs for which Medicare will reimburse these providers. *See* Social Security Act, 42 U.S.C. § 1395x(v)(1)(a) (1982 & Supp. III 1985) (directing Secretary of HEW to prescribe requirements to determine reasonable costs); 42 C.F.R. § 405.460 (1987).

83. Social Security Act, 42 U.S.C. § 1359cc(a)(1) (1982).

84. Social Security Act, 42 U.S.C. § 1395u(b)(3)(F) (1982 & Supp. III 1985); MEDICARE: PAYING THE PHYSICIAN, *supra* note 47, at 20.

85. Social Security Act, 42 U.S.C. § 1395L(a)(1) (1982 & Supp. III 1985); 42 C.F.R. §§ 405.501-.515 (1986).

86. *Id.* § 1395u(b)(3)(F); *see* 42 C.F.R. § 405.502(f)(5) (1986) (discussing determination of reasonable charges relating to office based physicians).

87. *See* Social Security Act, 42 U.S.C. § 1395(f)(a)(2) (1982 & Supp. III 1985)

Unlike payments under Part A, physicians and suppliers paid under Part B are not required to accept this calculated Medicare payment as payment in full on any benefit claim unless they accept the claim from the beneficiary.⁸⁸

2. *Ramifications of Early Payment Methodologies*

The problem of the Medicare program's high costs has plagued Congress and HHS policy makers since the program's inception and has dominated the health policy debate during this time. Early in the program, a consensus emerged among federal policy makers, Congress, and other observers that the cost reimbursement methodology was a fundamental cause of the inflation in Medicare hospital expenditures.⁸⁹ The theory was, simply, that since hospitals could be assured of payment for all the reasonable costs of covered services, they were rewarded for providing more services at higher cost. Physicians also had comparable incentives to provide more services at greater costs to the Medicare program. While lucrative for hospitals and physicians, these incentives had translated into increasingly higher costs for the Medicare program and resulted in pressure on the administrations of both political parties. Congress and the hospital industry felt pressure to develop ways of reducing the increased rate of Medicare hospital expenditures.⁹⁰ In 1983 Congress passed the prospective payment system, which fundamentally altered the way in which the Medicare program pays hospitals for services provided to Medicare beneficiaries.

Physicians, likewise, have comparable incentives to provide more services at greater cost to the Medicare program in the physician payment methodology under Part B. Specifically, physicians and suppliers can maximize reimbursement by breaking down services into components for which individual charges can be made.⁹¹ The Part B payment meth-

(delineating certification requirements for physicians); Social Security Act, 42 U.S.C. § 1395u(b)(3)(F) (1982 & Supp. III 1985) (requiring carriers to determine charges by customary and prevailing charges in effect at time service was rendered); *see also* 42 C.F.R. § 405.503 (1986) (explaining how to calculate varying charges).

88. *See* MEDICARE: PAYING THE PHYSICIAN, *supra* note 47, at 3 (discussing major features of Part B program).

89. *See* M. FELDSTEIN AND A. TAYLOR, THE RAPID RISE OF HOSPITAL COSTS (1977); M. ZUBKOFF, I. RASKIN & R. HANFT, HOSPITAL COST CONTAINMENT (1978). A similar consensus emerged with respect to skilled nursing facility costs, and Congress and HHS have inaugurated several cost containment strategies and reforms in the reimbursement of skilled nursing facilities over the years.

90. *See* *Twenty Years of Medicare and Medicaid* (1985 Annual Supp.), *supra* note 4 (comments of Senator David Durenberger and Congressmembers Daniel Rostenkowski, J. Alexander McMahon, and Michael D. Bromberg).

91. *See* Jencks and Dobson, *supra* note 47, at 1494 (providing current reimburse-

odology has also encouraged unwarranted growth in Medicare expenditures for Part B services. Thus, Congress and HHS are currently considering major reforms of Part B payment methodologies.⁹²

B. *The Search for Solutions*

To control these growing Medicare program expenditures, Congress and HEW adopted numerous cost containment strategies and conducted several demonstration projects to explore possible cost saving alternatives to Medicare payment methodologies. These efforts were targeted primarily at rising hospital costs because policy makers perceived this as the greatest problem area. Some measures were targeted at skilled nursing facilities and home health agencies as well. Recently, policy makers and Congress focused their attention more heavily on the problems concerning the cost of services under Part B.

1. *Early Hospital Payment Reform*

The Social Security Amendments of 1972. In the Social Security Amendments of 1972,⁹³ Congress adopted several regulatory measures to control rising hospital costs. The most important of these measures was enacted as section 223 of the Social Security Amendments of 1972.⁹⁴ Section 223 provides that Medicare should not reimburse any costs that are unnecessary for the provision of patient care services. In addition, the regulations promulgated under section 223 impose a limit on costs for routine inpatient services.⁹⁵ With these limits, the Medicare program departed from recognizing and paying all the hospital costs that previously were provided to Medicare beneficiaries and imposed regulatory controls that forced hospitals to deliver services in a more cost effective manner.

A second measure imposed by the Social Security Amendments of 1972 authorized the Secretary of HEW to withhold Medicare reim-

ment incentives); see also *Reform of Medicare Payments to Physicians: Hearings Before the Subcomm. on Health of the Senate Comm. on Finance, 99th Cong., 1st Sess. 6 (1985)* [hereinafter *Reform of Medicare Payments to Physicians*] (observing criticism of billing separately for services previously consolidated).

92. See *infra* notes 170-86 and accompanying text (discussing reforms to Part B payment methodologies).

93. Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (1972) [hereinafter *Social Security Amendments of 1972*].

94. Social Security Amendments of 1972 (codified as amended at 42 U.S.C. § 1395x(v) (1982 & Supp. III 1985)).

95. See 42 C.F.R. § 405.504 (1986) (delineating factors carriers considered in developing limits on routine costs).

bursement of capital costs associated with a hospital's capital expenditures if the capital expenditures were found by a designated state health planning agency to be inconsistent with the state's own health planning criteria, standards, and health plans.⁹⁶ The Social Security Amendments of 1983 required states to adopt capital expenditure review programs pursuant to section 1122 of the Social Security Act that met certain criteria if Congress did not incorporate capital costs into the Medicare prospective payment system by 1986.⁹⁷ Congress subsequently extended this deadline to Fiscal Year 1987.⁹⁸ This provision, however, has not been implemented, and it appears likely that it will not be implemented in the future since Congress or HHS will probably incorporate capital costs into the prospective payment system during Fiscal Year 1987.

Assuming that the excess and unnecessary utilization of hospital services by Medicare beneficiaries was the fundamental cause of escalating Medicare costs and that the required utilization review of hospitals for Medicare patients was ineffective, Congress authorized the creation of federally funded, private Professional Standards Review Organizations (PSRO's).⁹⁹ PSRO's were to conduct independent utilization and quality reviews of hospital services under the Medicare and Medicaid programs.¹⁰⁰ The concept was that physicians would review the quality and appropriateness of health care services which their peers provided to Medicare beneficiaries.

Difficulties arose, however, in the implementation of the PSRO program, and the program experienced only equivocal success.¹⁰¹ Physi-

96. See Social Security Amendments of 1972, 86 Stat. 1329, 1386 (codified as amended at 42 U.S.C. § 1320a-1 (1982 & Supp. III 1985)) (assuring federal funds are not used to support unnecessary capital expenditures).

97. Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 65, 162 (codified as amended at 42 U.S.C. § 1395ww(g)(1) (1982 & Supp. III 1985)) [hereinafter Social Security Amendments of 1983].

98. Urgent Supplemental Appropriations Act, Pub. L. No. 99-349, § 206 (1986) (amending 42 U.S.C. § 1395ww(a)(4) (1982)).

99. See Social Security Act, 42 U.S.C. § 1395x(k) (1982) (delineating utilization review plan requirements). As a condition of participation in the Medicare program, hospitals had to have a utilization review program to evaluate the medical necessity and appropriateness of hospital services provided Medicare beneficiaries. *Id.* Similar requirements were imposed on skilled nursing facilities. *Id.*

100. 42 U.S.C. § 249F(b) (1982) (amending 42 U.S.C. §§ 1301 to 1320c-12).

101. See, e.g., *PSRO Proposals: Hearings on S. 1250, S. 2142 Before the Subcomm. on Health of the Senate Comm. on Finance, 97th Cong., 2d Sess.* (1982); *Proposed Phaseout of PSRO's and Utilization Review Requirements: Hearings Before the Subcomm. on Health of the Senate Comm. on Finance, 97th Cong., 1st Sess.* (1981); *Professional Standards Review Organization (PSRO) Program: Hearings Before the Subcomm. on Oversight and the Subcomm. on Health of the House Comm. on Ways and Means, 97th Cong., 1st Sess.* (1981) (discussing weaknesses and methods for

cians unsuccessfully challenged the program on the grounds that it violated the constitutional rights of physicians and their patients.¹⁰² Ultimately, federal policy makers and Congress questioned the effectiveness of the program in controlling costs.¹⁰³ In its early years, the Reagan administration sought to dismantle the program on the grounds that it was ineffective and overly regulatory.¹⁰⁴ Congress formally terminated the program, while still embracing the concept of peer review as a strategy for controlling Medicare utilization, when it repealed the 1972 PSRO legislation and enacted the Peer Review Improvement Act of 1982.¹⁰⁵

Medicare Payment Demonstration Projects. Shortly after the Medicare program began, Congress authorized the Secretary of HEW to waive Medicare program requirements for the purpose of conducting demonstrations involving different methods of paying providers under the Medicare program.¹⁰⁶ In the Social Security Amendments of 1972, Congress further expanded the demonstration authority to allow testing of prospective payment methodologies.¹⁰⁷ Over the next ten years Congress conducted several of these demonstrations in various states.¹⁰⁸ The hypotheses being tested in these demonstrations were, first, whether a retrospective cost method of reimbursement was inflationary because it contained incentives for hospitals to provide excessive services and, second, whether paying hospitals a predetermined price or requiring hospitals to stay within an overall limit or budget regardless

strengthening the PSRO program).

102. Association of Am. Physicians and Surgeons v. Weinberger, 395 F. Supp. 125 (N.D. Ill. 1975), *aff'd mem.*, Association of Am. Physicians and Surgeons v. Mathews, 423 U.S. 975 (1975). *But see* Gosfield, *Medical Necessity in Medicare and Medicaid: The Implications of Professional Standards Review Organizations*, 51 TEMP. L.Q. 229 (1978) (refuting claims that PSRO's interfere with doctor-patient relationships).

103. See sources cited *supra* note 101.

104. See *PSRO Proposals: Hearings on S. 1250, S. 2142 Before the Subcomm. on Health of the Senate Comm. on Finance, 97th Cong., 2d Sess. 6-11 (1982)* (statement of George Thompson) (stating need for new legislation on PSRO's); Executive Office of the President, Office of Management and Budget, *FY 1982 Budget Revisions 70* (1981).

105. Peer Review Improvement Act of 1982 of the Tax Equity and Fiscal Responsibility Act of 1982, §§ 141-150 (amending 42 U.S.C. §§ 1320c-1 to 1320c-12 (1982 & Supp. III 1985)). The concept of peer review as a means of controlling costs under Medicare is reflected in the Peer Improvement Act. *Id.*

106. See Social Security Amendments of 1967, Pub. L. No. 90-248, § 402, 81 Stat. 821, 930-31 (1967) (discussing incentives for economy while maintaining or improving quality of health services).

107. Social Security Amendments of 1972, 86 Stat. 1329, 1392.

108. See Health Care Financing Administration, *The National Hospital Rate-Setting Study: A Comparative Review of Nine Prospective Rate-Setting Programs* (Aug. 1980) (reporting on demonstrations). It should be noted that the DRG pricing concept was tested in the New Jersey prospective payment demonstration.

of costs provided the appropriate incentives for hospitals to contain costs.

These hypotheses bore out in the demonstrations and by evidence from prospective payment systems for other third party payers besides Medicare.¹⁰⁹ Congress and the states were so impressed with the results obtained by these state prospective payment systems that Congress then authorized the states to establish these systems on a non-experimental basis for Medicare and other payers in the Tax Equity and Fiscal Responsibility Act of 1982.¹¹⁰ In the Social Security Amendments of 1983, Congress expressly allowed states to opt out of the already existing Medicare prospective payment system and to establish their own state prospective payment systems for all payers.¹¹¹

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). TEFRA instituted major reforms to address the cost problems in the Medicare program.¹¹² In TEFRA, Congress modified the existing per diem cost limit established under section 223 of the Social Security Amendments of 1972,¹¹³ and substituted limits on costs for each Medicare patient case.¹¹⁴ This change to regulation on a per case rather than a per diem basis represented an important conceptual departure from previous cost containment strategies. Furthermore, it was an important step in moving hospitals toward a prospective payment system.

TEFRA also imposed a limitation on the rate of increase permitted in a hospital's routine operating costs.¹¹⁵ Hospitals with cost increases exceeding their target rate were penalized, while hospitals that kept

109. See Biles, Schramm & Atkinson, *Hospital Cost Inflation Under State Rate-Setting Programs*, 303 NEW ENG. J. MED. 664 (1980) (concluding that annual rate of increase in hospital costs in rate-setting statutes was 3.1% lower than states without such programs); Cromwell and Hewes, *Medicare Expenditures and Utilization under State Hospital Rate Setting*, HEALTH CARE FIN. REV. 97 (Fall 1985); Steinwald and Sloan, *Regulatory Approaches to Hospital Cost Containment: A Synthesis of the Empirical Evidence*, reprinted in A NEW APPROACH TO THE ECONOMICS OF HEALTH CARE (M. Olson ed. 1981) (examining successes and failures of hospital regulatory programs and discussing current trends in public policy towards hospital industry).

110. Tax Equity and Fiscal Responsibility Act of 1982, § 101(a)(1) (codified as amended at 42 U.S.C. § 1395ww(c) (1982)).

111. 42 U.S.C. § 1395ww(c) (Supp. III 1985); see American Hospital Association, *How States Can Opt Out of the Federal Medicare DRG System: A Summary of Legal Issues* (1983). Currently, only Maryland and New Jersey have Medicare waivers to operate state all-payer prospective payment systems.

112. Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324 (1982) (providing tax equity and fiscal responsibility for health services).

113. See *supra* notes 93-96 and accompanying text (discussing Social Security Amendments of 1972).

114. Tax Equity and Fiscal Responsibility Act of 1982, 42 U.S.C. § 1395ww(a)-(b) (1982 & Supp. III 1985).

115. *Id.* § 1395ww(a).

increases below their target rate received part of the realized savings.¹¹⁶ Allowing hospitals to retain savings amounted to a radical departure from previous cost containment strategies. Congress conceived the TEFRA limits as the foundation for a future prospective payment system. To this end, TEFRA directed HHS to prepare a legislative proposal for the creation of a prospective payment system on hospitals for consideration in the next session of Congress.¹¹⁷

The Peer Review Improvement Act of 1982. As part of TEFRA, Congress enacted the Peer Review Improvement Act. This Act established a new peer review program to perform utilization and quality review of hospital services provided to Medicare beneficiaries.¹¹⁸ To conduct these review activities, Congress authorized the Secretary to contract with private, physician-controlled peer review organizations that possessed certain characteristics¹¹⁹ for each state or region of the country.¹²⁰ Specifically, PRO reviews were to be conducted and supervised by licensed physicians with active admitting privileges in local hospitals. Only these physicians could make a final determination to deny payment for services provided to Medicare.¹²¹ As of November

116. *Id.* § 1395ww(b)(1).

117. *Id.* § 1320b-5(c). This statutory directive also called for HHS to develop a legislative proposal for prospective payment of skilled nursing facilities. *Id.* HHS has not developed this proposal to date. Nevertheless, Congress instituted prospective payment based on per diem costs for skilled nursing facilities having a small census of Medicare Patients. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, Title IX, 59126, 100 Stat. 82, 168-70 (1986) [hereinafter Consolidated Omnibus Budget Reconciliation Act of 1985] (codified as amended in Social Security Act, 42 U.S.C. § 1395yy (1982)).

118. Peer Review Improvement Act of 1982 of the Tax Equity and Fiscal Responsibility Act of 1982, §§ 141-150 (codified as amended at 42 U.S.C. § 1320c-1 to § 1320c-12 (1982)); see Dans, Weiner & Otter, *Peer Review Organizations: Promises and Pitfalls*, 31 NEW ENG. J. MED. 1131 (1985); Gosfield, *Hospital Utilization Control by PROs: A Guide Through the Maze*, HEALTHSPAN 3 (Feb. 1985); Grimaldi & Micheletti, *Implementation of the Peer Review Organization Program*, QRB 340 (Nov. 1984).

119. To qualify as a PRO, an organization must be either a "physician-sponsored" or "physician-access" organization. Social Security Act, 42 U.S.C. § 1320c-2(a)(1) (Supp. II 1984); 42 C.F.R. § 462.101 (1986). A physician-sponsored organization is composed of a substantial number, i.e., 20% of the practicing physicians in the community. 42 C.F.R. § 462.102(b)-(c). A physician-access organization may be a nonprofit or for-profit organization established to conduct peer review but must demonstrate that it uses physicians in its review functions. *Id.* § 462.103. A PRO may not have any formal association with a medical facility. Social Security Act, § 1153(b)(3), 42 U.S.C. § 1320c-2(a)(2)(C) (1982).

120. Social Security Act, 42 U.S.C. § 1320c-2(a)(2)(B) (1982); see also 42 C.F.R. § 462.107 (1986) (establishing requirements for PRO contract award). Congress also authorized designation of a "Super PRO" to evaluate the performance of PRO's. Social Security Act, 42 U.S.C. § 1320c-2 (1982).

121. Social Security Act, 42 U.S.C. § 1320c-3(c) (1982).

1985, HCFA had contracted with 54 PRO's covering all the states and territories. Most of these PRO's were formerly PSRO's supported by the state medical association, and in some cases the state medical association was also the PRO.

The PRO's chief function is to ensure the medical necessity, quality, and appropriateness of hospital services provided to Medicare beneficiaries.¹²² In addition, under the prospective payment program, Congress accorded to PRO's important new monitoring functions. To accomplish these functions effectively, PRO's have authority to deny Medicare payment for inappropriate or unnecessary services and to recommend that certain providers and physicians be excluded temporarily, or even permanently, from the Medicare program because of their utilization patterns and practices.¹²³ Congress has accorded PRO's a broader scope of review, greater authority, and more flexibility than PSRO's had previously enjoyed. This flexibility was enhanced by Congress authorizing the Secretary to contract with PRO's for the performance of agreed upon functions and by the program meeting agreed upon goals during the two-year contract period.¹²⁴ By statute, the PRO contract must specify the negotiated objectives to be obtained by the PRO and against which its performance will be judged, must require the PRO to perform statutorily mandated review activities and other functions, and must state the Secretary's right to evaluate the quality and effectiveness of the PRO in discharging its contracted functions.¹²⁵

HHS's implementation of the PRO program has been controversial. HCFA was very slow in its implementation of the program. These delays were a matter of considerable concern to Congress, as it had endorsed the concept that only physician-controlled entities were qualified to make the Medicare coverage determination whether the medical criteria for coverage of hospital services had been met and whether hospitals were providing quality services to Medicare beneficiaries.¹²⁶ One

122. Social Security Act, 42 U.S.C. § 1320c-3(a)(1) (1982).

123. Social Security Act, 42 U.S.C. § 1320c-5(b)(1) (1982); 50 Fed. Reg. 15,335, 15,345 (1985) (to be codified at 42 C.F.R. § 474.32 (1986)). Furthermore, the regulations require that the provider responsible for inappropriate or unnecessary services pay the cost of these services within six months of a denial notice. *Id.*

124. Social Security Act, 42 U.S.C. § 1320c-2(b)(1) (1982). Under the PSRO program, the Secretary awarded grants to PSRO's, and PSRO functions and objectives were specified by statute and regulation. See A. Gosfield, *supra* note 102, at 9. Congress concluded that these characteristics of the PSRO program were partially responsible for the poor performance of PSRO's.

125. Social Security Act, 42 U.S.C. § 1320c-2(c) (1982).

126. See *Peer Review Organizations: Hearings Before the Subcomm. on Health of the Senate Comm. on Finance, 99th Cong., 1st Sess. 2* (1985) [hereinafter *Senate Finance Comm. Hearings on Peer Review Organizations*] (reviewing quality and appro-

cause of the controversy has been HCFA's reliance on program directives and contract provisions that delineate the specific responsibilities given to PRO's under the PRO program.¹²⁷ The American Hospital Association successfully challenged this implementation method in *American Hospital Association v. Bowen*.¹²⁸ In this decision, the United States District Court for the District of Columbia invalidated many of the program directives that HCFA used to implement the PRO program on grounds that they were not promulgated as rules under the Administrative Procedure Act.¹²⁹

Congress has exhibited considerable dissatisfaction with the implementation of the PRO program. The Senate Finance Committee has, on three occasions, held hearings dealing with the program's implementation.¹³⁰ In the Consolidated Omnibus Budget Reconciliation Act of 1985, Congress instituted several PRO program changes aimed at increasing the responsibilities placed on PRO's when they monitor the quality of hospital care for Medicare beneficiaries.¹³¹ Even with these changes in the PRO program, Congress was still not satisfied with its performance. Hence, Congress made additional legislative reforms in the Omnibus Budget Reconciliation Act of 1986. These reforms will try to improve PRO quality of care reviews and enhance the protection of beneficiaries against decisions by PRO's and hospitals regarding the need for a beneficiary's continued hospital care.¹³²

priateness of inpatient hospital services to Medicare beneficiaries under prospective payment system); *Implementation of PRO's for Medicare: Hearings Before the Subcomm. on Health of the Senate Comm. on Finance*, 98th Cong., 2d Sess. 38-40 (1984) [hereinafter *Senate Finance Comm. Hearings on Implementation of PRO's for Medicare*]; *Examination of Quality of Care Under Medicare's Prospective Payment System: Hearings Before the Senate Committee on Finance*, 99th Cong., 2d Sess. 23 (1986).

127. See PRO Manual IM85-2, replacing PSRO Transmittal No. 107; PRO Manual IM85-3, replacing PSRO Transmittal No. 108; Medicare Hospital Manual Transmittal No. 367 § 287.4A; and Medicare Intermediary Manual transmittal No. 1079 § 3789c and No. 1102; PRO Directive No. 2; Request for Proposal (RFP No. HCFA-84-015, Feb. 29, 1984).

128. 640 F. Supp. 453 (D.D.C. 1986); see Duffy, *PRO-Court grants Secretary's Motion for Stay*, HEALTH L. VIGIL 4 (Oct. 10, 1986).

129. 5 U.S.C. § 553 (1982 & Supp. III 1985).

130. See sources cited *supra* note 126.

131. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, Title IX, §§ 9401-9406, 100 Stat. 82, reprinted in 1986 U.S. CODE CONG. & ADMIN. NEWS (1986) [hereinafter COBRA] (codified as amended in scattered sections of 42 U.S.C.).

132. Omnibus Budget Reconciliation Act of 1986, §§ 9305, 9313, 9353, 100 Stat. 1988-94, 2002-5, 2044-9 (1986); see H.R. REP. NO. 727, 99th Cong., 2d Sess. 457-60 (1986); S. REP. NO. 348, 99th Cong., 2d Sess. 146-48 (1986).

2. *The Solution to the Hospital Cost Problem: The Prospective Payment System*

As the solution to the problem of inflationary hospital costs, Congress enacted legislation instituting the prospective payment system.¹³³ This system, which started operating October 1, 1983, fundamentally altered the manner in which Medicare pays acute care hospitals for their services rendered to Medicare beneficiaries.¹³⁴ Specifically, Congress discontinued paying hospitals for the reasonable cost of covered services on a retrospective basis and supplanted it with a program paying hospitals by a prospectively determined price for each Medicare case.

Setting Hospital Payment Rates. The prospective payment system, established by the Social Security Amendments of 1983, pays hospitals a predetermined fixed price for each patient case regardless of the cost the hospital incurs in treating that patient. Medicare establishes the price beforehand, and hospitals retain savings if they treat the patient for less than that price, thus giving hospitals an incentive to use less resources and reduce costs in treating patients.¹³⁵ Prices for Medicare hospital cases are based on a comprehensive classification system comprised of 470 mutually exclusive categories called "Diagnosis Related Groupings" (DRG's).¹³⁶ The basic premise of DRG's is that all human disease conditions can be classified according to disease system, length of stay, intensity of resources consumed, morbidity, and sex and that

133. Social Security Amendments of 1983, § 601(e) (codified as amended at 42 U.S.C. § 1395ww(d) (Supp. III 1985)).

134. The prospective payment system applies only to acute care hospitals; rehabilitation, psychiatric and children's hospitals are not included in the prospective payment system nor are units in acute care hospitals that provide rehabilitative, psychiatric or pediatric services. Social Security Act, 42 U.S.C. § 1395ww(d)(1)(B) (Supp. III 1985); 42 C.F.R. §§ 412.20-32 (1986). The Secretary is also authorized to make exceptions and adjustments under the prospective payment system for regional and national referral centers, sole community hospital, cancer hospitals and hospitals serving a disproportionate number of Medicare and low income patients. Social Security Act, § 1886(d)(5)(C), 42 U.S.C. § 1395ww(d)(5)(C); 42 C.F.R. §§ 412.90-104 (1986).

135. H.R. REP. NO. 25, 98th Cong., 1st Sess. 132 (1983); Secretary of the Department of Health and Human Services, *Report to Congress on Hospital Prospective Payment for Medicare 101-10* (1982); see *Hospital Prospective Payment System: Hearings Before the Subcomm. on Health of the Senate Comm. on Finance*, 98th Cong., 1st Sess. (1983) (discussing fixed rate payment for DRG's); *Medicare Hospital Prospective Payment System: Hearings Before the Subcomm. on Health of the House Comm. on Ways and Means*, 98th Cong., 1st Sess. (1983) (examining fixed rate payment for DRG's); *Twenty Years of Medicare and Medicaid*, supra note 4 (1985 Annual Supp.) (comments of J. Alexander McMahon and Congressman Dan Rostenkowski).

136. Social Security Amendments of 1983, § 601 (e) (codified as amended at 42 U.S.C. § 1395ww(e) (1982 & Supp III 1985)).

such categories reflect the average cost of providing hospital services to all patients with diseases that fall in a DRG.¹³⁷ The final price is determined by taking the product of an average price per case for all Medicare cases, called the "standardized amount,"¹³⁸ and the weight of the DRG assigned to the particular patient's case, according to the following formula: standardized amount multiplied by DRG weight equals

137. Preamble to Interim Final Rule, 48 Fed. Reg. 39,752, 39,760-61 (1983); see Prospective Payment Assessment Commission, *Technical Appendixes to the Report and Recommendations to the Secretary, U.S. Department of Health and Human Services, April 1, 1985*, Appendix A, at 14-17 [hereinafter *Technical Appendixes to the ProPAC Report*].

138. Social Security Act, § 1886(d)(2)(D), 42 U.S.C. § 1395ww(d)(2)(D) (1982 & Supp. III 1985).

The calculation of the standardized amount is complicated. Through fiscal year 1986, the standardized amount included two components: (1) the individual hospital's average cost per Medicare case, i.e., the hospital-specific component; and (2) the average cost per case for all urban and all rural hospitals, i.e., the federal component. The hospital-specific component is based on the hospital's costs as determined in its base year under the prospective payment system, i.e., Fiscal Year 1982. *Id.* §§ 1886(b)(3)(A), 1886(d)(1), 42 U.S.C. §§ 1395ww(b)(3)(A), 1395ww(d)(1) (1982 & Supp. III 1985); 42 C.F.R. §§ 412.71-.73 (1986). It is standardized to remove the effect of the hospital's case mix and adjusted to account for inflation, outlier payments, and a factor that will assure "budget neutrality" of the prospective payment system in Fiscal Year 1984 and Fiscal Year 1985. Social Security Act, § 1886(d)(1)(A), 42 U.S.C. § 1395ww(d)(1)(A) (1982 & Supp. III 1985); 42 C.F.R. § 412.73 (1986).

The federal component is calculated according to a formula with five steps: (1) removing costs that are not included in the prospective payment rate; (2) updating for inflation and other changes that affect hospital performance; (3) standardizing the costs per case to remove costs attributable to explainable differences between hospitals, i.e., area wage rates, teaching status and case mix; (4) aggregating and averaging the standardized amount for all urban and all rural hospitals; and (5) making other adjustments required by law. Social Security Act, § 1886(d)(2), 42 U.S.C. § 1395ww(d)(2) (1982 & Supp. III 1985); 42 C.F.R. § 412.73 (1986); see *Technical Appendixes to the ProPAC Report, supra* note 137, Appendix A, at 5 (outlining elements in calculation of prospective payment system).

During the transition period from Fiscal Year 1984 to Fiscal Year 1986, the proportion of the hospital specific component declined while the federal component increased. Social Security Act, § 1886(d)(2)(D), 42 U.S.C. § 1395ww(d)(2)(D) (1982 & Supp. III 1985); 42 C.F.R. § 412.70 (1986). As of Fiscal Year 1987, the standardized amount is based only on the federal component. Social Security Act, § 1886(d)(1)(A)(iii), 42 U.S.C. § 1395ww(d)(1)(A)(iii) (1982 & Supp. III 1985); 42 C.F.R. § 412.70 (1986).

Currently and in the past, there has been a separate standardized amount derived for urban hospitals and for rural hospitals. Social Security Act, § 1886(d)(1)(A)(iii), 42 U.S.C. § 1395ww(d)(1)(A)(iii) (1982 & Supp. III 1985); 42 C.F.R. § 412.70 (1986). Further, the final standardized amount for both urban and rural hospitals has always been divided into components reflecting labor and nonlabor costs, and the labor component is adjusted to reflect the wage level for the area in which the individual hospital is located and adjusted for differences in urban and rural hospitals. Social Security Act, § 1886(d)(2)(H), 42 U.S.C. § 1395ww(d)(2)(H) (1982 & Supp. III 1985); 42 C.F.R. § 412.63(g) (1986); see *Technical Appendixes to the ProPAC Report, supra* note 137, Appendix A (describing prospective payment system design).

price per case.¹³⁹ If a case is a so-called "outlier" and greatly exceeds the cost and length of stay ordinarily required for a case in the DRG to which the case would be assigned, Medicare will pay more for that case than the DRG price.¹⁴⁰

Not all hospital costs are included in the DRG prices. Capital costs are excluded indefinitely and reimbursed separately.¹⁴¹ In addition, direct costs of medical education are also reimbursed separately.¹⁴² The prospective payment system also pays an allowance for teaching activities in hospitals.¹⁴³

The Social Security Amendments of 1983 require that the Secretary annually update payments to hospitals under the prospective payment system through the informal rulemaking process.¹⁴⁴ Specifically, updating hospital payment rates involves two activities: (1) adjusting the standardized amount to reflect inflation, hospital productivity, new technology, and other factors; and (2) readjusting the DRG's to reflect changes in resource consumption due to new technology and other factors.¹⁴⁵

To assist in the process of setting and updating the hospital payment rates in a substantive and public fashion, Congress created the Prospective Payment Commission (ProPAC).¹⁴⁶ This Commission is composed of seventeen health care experts who are appointed by the Director of

139. *Technical Appendixes to the ProPAC Report, supra* note 137, Appendix A, at 4.

140. Social Security Act, § 1886(d)(5)(A)(i), 42 U.S.C. § 1395ww(d)(5)(A)(i) (1982 & Supp. III 1985); 42 C.F.R. § 412.80 (1986).

141. Social Security Act, § 1886(a)(4)(C), 42 U.S.C. § 1395ww(a)(4)(C) (1982 & Supp. III 1985). In the Omnibus Budget Reconciliation Act of 1986, Congress specifically provided that capital costs would remain outside the prospective payment system indefinitely but imposed a limit on capital costs for Fiscal Year 1987 through Fiscal Year 1989. Capital costs are reimbursed separately according to retroactive cost reimbursement principles. In the Social Security Amendments of 1983, Congress stated its intent to include capital costs in DRG prices by October 1986 and directed the Secretary to report to Congress by October 1984 on proposals for incorporating capital costs into DRG prices. Social Security Amendments of 1983, § 603(a)(1) (1983); see Department of Health and Human Services, *Report to Congress, Hospital Capital Expenses: A Medicare Payment Strategy for the Future* (1986).

142. Social Security Act, § 1886(a)(4), 42 U.S.C. § 1395ww(a)(4) (1982 & Supp. III 1985); see Preamble, Medicare Program, Prospective Payments for Medicare Inpatient Hospital Services, 48 Fed. Reg. 39,777 (1983) (discussing interim payment plan).

143. Social Security Act, § 1886(d)(5)(B), 42 U.S.C. § 1395ww(d)(5)(B) (1982 & Supp. III 1985); 42 C.F.R. § 405.421 (1986); see Preamble, 48 Fed. Reg. 39,778 (1983) (elaborating on payment procedures).

144. Social Security Act, § 1886(e)(5)(A), 42 U.S.C. § 1395ww(e)(5)(A) (1982 & Supp. III 1985).

145. The Social Security Amendments of 1983, § 601(e) (codified as amended at 42 U.S.C. § 1395(d)(2)(B), (3)(A), (4)(C) (1982 & Supp. III 1985)).

146. Social Security Act, 42 U.S.C. §§ 1395ww(e)(2)-(3) (Supp. III 1985); see H.R. REP. NO. 911, 98th Cong., 2d Sess. 140 (1984).

the congressional Office of Technology Assessment (OTA).¹⁴⁷ The Commission must, by statute, include representatives from the medical profession, the hospital industry, and health manufacturers as well as representatives from business, labor, health insurance programs, and the elderly.¹⁴⁸ ProPAC has two statutory responsibilities: (1) to make annual recommendations to the Secretary on what constitutes the appropriate percentage change in the Medicare payments made for hospital services (called the update factor); and (2) to make recommendations to the Secretary on any necessary changes that should be made in the Diagnosis Related Groupings (DRG's), including the advisability of establishing new DRG's, modifying existing DRG's, or changing the relative weights of the DRG's.¹⁴⁹

To ensure that ProPAC has the contemplated influence in setting hospital payment rates, Congress mandated that ProPAC and HHS adhere to a formal schedule of public communications on the subject of the annual updating necessary in hospital payment rates. Furthermore, Congress has required that the Secretary, in his proposed rules on the subject of updating hospital payment rates, include ProPAC's April recommendations.¹⁵⁰ In the Omnibus Budget Reconciliation Act of 1986, Congress also required the Secretary to submit his proposed rule with accompanying documentation to Congress before publication in the *Federal Register*.¹⁵¹ After publication of the final rule, which must be completed by September 1,¹⁵² ProPAC must report to Congress with an analysis of the Secretary's current update of the payment rates in the final rule.¹⁵³

Ensuring Quality of Care. In the Social Security Amendments of 1983, Congress gave PRO's the responsibility to monitor hospital performance under the prospective payment system. Specifically, it charged PRO's with reviewing and determining, for payment purposes,

147. Social Security Act, 42 U.S.C. §§ 1395ww(e)(2), 1395ww(e)(6) (Supp. III 1985).

148. Social Security Act, 42 U.S.C. § 1395ww(e)(6)(B) (Supp. III 1985).

149. Social Security Act, 42 U.S.C. §§ 1395ww(e)(3), 1395ww(d)(4)(D) (Supp. III 1985); see Prospective Payment Assessment Commission, *Report and Recommendations to the Secretary, U.S. Department of Health and Human Services, April 1, 1985*, at 3 [hereinafter *ProPAC Report and Recommendations*] (recommending adjusting all DRG weights utilizing newer, more complete, and more accurate data).

150. Social Security Act, 42 U.S.C. § 1395ww(e)(5) (Supp. III 1985).

151. Omnibus Budget Reconciliation Act of 1986, § 9302(e)(3) (amending Social Security Act § 1886(a)(4), 42 U.S.C. § 1395ww(e)(3) (Supp. III 1985)).

152. Social Security Act, 42 U.S.C. § 1395ww(e)(5)(B) (Supp. III 1985).

153. Social Security Act, 42 U.S.C. § 1395ww(d)(4)(D) (Supp. III 1985); see *1986 Adjustments to the Medicare Prospective Payment System: ProPAC Report to the Congress (November 1985)*.

“the validity of diagnostic information provided by [a] hospital, the completeness, adequacy and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care for which additional payments are sought.”¹⁵⁴ Congress also gave HHS the authority to impose sanctions on hospitals that exhibit inappropriate admissions and discharge practices.¹⁵⁵

As a condition of payment, a hospital must have an agreement with the designated area PRO which enables the PRO to conduct the requisite reviews.¹⁵⁶ Specifically, PRO's review the admission and discharge patterns of hospitals, employment of certain procedures, admissions for certain types of treatment, and all claims of outlier cases for which hospitals seek additional payment.¹⁵⁷ Furthermore, a PRO must review any case in which a hospital advises a beneficiary that Medicare does not cover certain services and where the hospital accordingly charges him for these services.¹⁵⁸ Congress has paid considerable attention to the level of PRO performance in conducting these reviews and has considered, and even acted, to make changes in the requirements to improve reviews of the quality of hospital care.¹⁵⁹

Ramifications for the American Health Care System. The prospective payment system has had an enormous impact on the American health care system and the Medicare appeals system. First, and highly important, is the fact that hospitals have done very well under the prospective payment system. Indeed, in 1984 the hospital industry made record profits — an increase of 27.6% from 1983.¹⁶⁰ These profits have been so great that Congress and the HHS Inspector General have launched inquiries and have made recommendations for changes.¹⁶¹ In

154. Social Security Act, § 1866(a)(1)(F), 42 U.S.C. § 1395cc(a)(1)(F) (Supp. III 1985); see H.R. REP. NO. 47, 98th Cong., 1st Sess. 197 (1983) (noting that hospitals receiving payments under prospective payment system would be required to contract with a professional review organization).

155. Social Security Act, 42 U.S.C. § 1395ww(f)(2) (Supp. III 1985).

156. Social Security Act, 42 U.S.C. § 1395cc(a)(1)(F) (Supp. III 1985).

157. The review responsibilities of PRO's are outlined in the regulations. See 42 C.F.R. § 412.44 (1986). They are enumerated more specifically in the contracts themselves.

158. 42 C.F.R. § 412.42 (1986).

159. *Supra* notes 130-132 and accompanying text.

160. *National Health Expenditures, 1984*, *supra* note 12, at 13; see also Prospective Payment Assessment Commission, *Medicare Prospective Payment and the American Health Care System: Report to the Congress 51* (1986) [hereinafter cited as *ProPAC Report on the American Health Care System*].

161. Office of the Inspector General, Department of Health and Human Services, *Financial Impact of the Prospective Payment System on Medicare Participating Hospitals 1984; Hospital Profits Under PPS: Hearings Before the Subcomm. on Health of the Senate Comm. on Finance, 99th Cong., 2d Sess.* (1986).

addition, the prospective payment system has been quite successful in addressing the hospital cost problem and in curbing the rate of inflation in hospital costs. In 1984, the growth in hospital spending was the slowest in 19 years, and the 1984 Medicare inflation rate for hospital costs was 9.6% compared to the average annual rate of 16.7% between 1977 and 1983.¹⁶² This record profitability for the hospital industry, as well as the demonstrated success of the prospective payment system in meeting its goals, is critically important to keep in mind when evaluating the appeals issues that hospitals have raised.

The prospective payment system and other regulatory changes have also had a critical impact on the American health care system. In 1984, the number of hospital admissions of the elderly declined for the first time since 1965, the average length of stay continued to decline, and the data suggested that hospitals were taking care of a sicker group of patients than ever before.¹⁶³ Implementation of the prospective payment system has encouraged hospitals and physicians to treat more Medicare beneficiaries outside the hospital, and data showed that there was greater utilization of outpatient services in 1984 than in earlier years.¹⁶⁴ Many patients are discharged from hospitals sicker, and these patients are in greater need of skilled nursing and home health services after discharge.¹⁶⁵ There has been an increased utilization of Part B services, and these Part B services are more sophisticated and consequently more expensive than in previous years.¹⁶⁶

With these changes in the utilization patterns for health care resources has come an increased number of appeals of disputes over coverage and payment on home health services.¹⁶⁷ There has also been an

162. *ProPAC Report on the American Health Care System*, *supra* note 160, at 19-20; see also *National Health Expenditures, 1984*, *supra* note 12.

163. *ProPAC Report on the American Health Care System*, *supra* note 160, at 19-20; see also *Quality of Care Under Medicare's Prospective Payment System: Hearings Before the Senate Special Comm. on Aging, 99th Cong., 1st Sess. (1985)* [hereinafter *Hearings on Quality of Care Under Medicare's Prospective Payment System*].

164. *Id.*; Government Accounting Office, *Information Requirements for Evaluating the Impacts of Medicare Prospective Payment on Post-Hospital Long-Term-Care Services: Preliminary Report* (PEMD-85-8, Feb. 21, 1985).

165. *ProPAC Report on the American Health Care System*, *supra* note 160, at 60-61; Government Accounting Office, *Information Requirements for Evaluating the Impacts of Medicare Prospective Payment on Post-Hospital Long-Term-Care Services: Preliminary Report* (PEMD-85-8, Feb. 21, 1985); *Hearings on Quality of Care Under Medicare's Prospective Payment System*, *supra* note 163, at 118.

166. See Congressional Research Service, *Medicare Appeals Background Paper* (Oct. 1985), reprinted in *Medicare Appeals Provisions: Hearings on S. 1158 [sic] Before the Subcomm. on Health of the Senate Comm. on Finance, 99th Cong., 1st Sess. 2 (1985)* [hereinafter *Senate Hearings on Medicare Appeals Provisions*].

167. *Id.*

increase in the number of appeals of Part B coverage and payment determinations as well as the amount of money involved in Part B appeals.¹⁶⁸ Specifically, there was a 31% increase in requests for review determinations for Part B claims between 1983 and 1984 — the first year of the prospective payment system.¹⁶⁹

3. Physician Payment Reform

Congress and federal policy makers have paid much less attention to attempting to reform physician reimbursement programs than they did to reforming hospital reimbursement. In part, this is due to the fact that Part B costs represent a lower proportion of the total Medicare cost problem.¹⁷⁰ Another reason is that the medical profession is politically powerful and has resisted reforms in Part B. Since Medicare's inception in 1965, Congress has adopted only a small number of cost containment measures for Part B, and these measures have tended to address only the special problems of certain limited groups of physicians. The major reforms of Part B made before 1983 included: limiting the permissible rate of increase in the prevailing charge to an index that reflects inflation;¹⁷¹ reforming the payment methods for physicians in teaching hospitals;¹⁷² and tightening up the payment methods for hospital-based physicians, such as anesthesiologists, pathologists, and radiologists who have contract arrangements with hospitals.¹⁷³

Recent Legislative Reforms. In the Deficit Reduction Act of 1984 (DEFRA), Congress instituted its first major reform of the physician reimbursement program. Congress enacted DEFRA primarily as an interim measure to be imposed only until more comprehensive reforms could be enacted. As such, DEFRA imposed a freeze upon the charges made by physicians and suppliers of durable medical equipment for a fifteen-month period running from July 1, 1984 to September 1985.¹⁷⁴ The medical profession challenged this freeze unsuccessfully on consti-

168. *Id.*

169. *Id.*

170. See *supra* notes 73-80 and accompanying text (discussing distribution of hospital costs and physicians costs under Medicare).

171. Social Security Amendments of 1972 (codified as amended at 42 U.S.C. § 1395u(b)(3)(F) (1982)); 42 C.F.R. § 405.509 (1986).

172. Social Security Amendments of 1972, § 227(b)(2) (codified as amended at 42 U.S.C. § 1395f(g) (1982)).

173. Tax Equity and Fiscal Responsibility Act of 1982, § 108(a)(1) (codified as amended at 42 U.S.C. § 1395xx (1982)); 42 C.F.R. §§ 405.550-.557 (1986).

174. Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2306, Division B, Title III, 98 Stat. 494, 1070 (1984) [hereinafter Deficit Reduction Act of 1984] (current version at 42 U.S.C. § 1395u(b)(4) (Supp. III 1985)).

tutional grounds in *American Medical Association v. Heckler*.¹⁷⁵

DEFRA also contained incentives for physicians to accept assignment and become "participating physicians" in the Medicare program. Specifically, those physicians and suppliers who voluntarily accept an assignment for all Medicare patients are permitted, during the freeze period, to raise their charges for the purposes of calculating their future customary charge. Nonparticipating physicians and suppliers, however, are not permitted to raise their charges either in the present or for purposes of calculating future charges.¹⁷⁶ As a result of these incentives, nearly 30% of the physicians became participating physicians, and the number of assignments has increased dramatically.¹⁷⁷

In the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Congress made additional alterations in the payment methodologies employed under Part B. The chief measure extended the previously established freeze of charges by physicians and suppliers of durable medical equipment until September 1986. Another provision further enhanced the already existing incentives for physicians and suppliers to accept assignment and become participating physicians.¹⁷⁸ Furthermore, COBRA directed the Director of the Office of Technology Assessment (OTA) to appoint an eleven-member Physician Payment Review Commission by May 1, 1986. This Commission's duties include performing an analytical and evaluative function within the physician payment system comparable to the role of the Prospective Payment Assessment Commission under the prospective payment system for hospitals.¹⁷⁹

In the Omnibus Budget Reconciliation Act of 1986, Congress discontinued the charge freeze system, created in DEFRA and extended in COBRA, and established a new charge control program for physicians.¹⁸⁰ The basic concept in the new system is a Maximum Allowable Actual Charge imposing caps on physician charges.¹⁸¹ In addition, the

175. 606 F. Supp. 1422 (S.D. Ind. 1985).

176. Deficit Reduction Act of 1984, § 2306(c).

177. Health Care Financing Administration, *Medicare Participating Physician and Supplier Program: Fact Sheet* (Jan. 1985). Similar results were also obtained for suppliers of durable medical equipment as well. *Id.*

178. Consolidated Omnibus Budget Reconciliation Act of 1985, § 9301 (amending 42 U.S.C. § 1395u(b) (1982)).

179. Consolidated Omnibus Budget Reconciliation Act of 1985, § 9305 (amending Social Security Act, § 1845, 42 U.S.C. § 1395x (Supp. II 1984)).

180. Omnibus Budget Reconciliation Act of 1986, § 9331 (amending Social Security Act, § 1842, 42 U.S.C. § 1395u); see *American Medical Ass'n v. Bowen*, No. 3-86-3181-H (N.D. Tex. Jan. 20, 1987) (federal district court refusing to enjoin implementation of this program).

181. Omnibus Budget Reconciliation Act of 1986, § 9331(a).

Omnibus Budget Reconciliation Act of 1986 imposed a moratorium on the Secretary's authority to change the Medical Economic Index to which annual increases in physician's charges are keyed.¹⁸² This legislation also contained new incentives to encourage more physicians to accept assignment and become participating physicians under the Medicare program.¹⁸³

Congress and HHS have focused greater attention on how to achieve a reform of the various Part B payment methodologies. In the Social Security Amendments of 1983, Congress directed the Secretary to study possible methods of paying physicians according to a methodology based on Diagnosis Related Groupings.¹⁸⁴ This mandate precipitated a close examination of how Medicare pays physicians and other suppliers of services under Part B. Furthermore, it generated proposals to modify payment methodologies fundamentally under Part B.¹⁸⁵ Clearly, Congress plans to enact future legislation creating Part B payment methodologies that will be fundamentally different from those currently utilized by Medicare.¹⁸⁶

III. THE MEDICARE APPEALS SYSTEM

The Medicare appeals system can best be characterized as a patchwork¹⁸⁷ — a large number of independent appeal processes addressing a multitude of diverse issues. This diversity is in large part due to the

182. *Id.* § 9331(c).

183. *Id.* § 9332 (amending Social Security Act, § 1842, 42 U.S.C. § 1395u (1982)).

184. Social Security Amendments of 1983, § 603(a)(2)(B).

185. See *Proposals to Modify Medicare's Physician Payment System: Hearings Before the Senate Subcomm. on Health of the Comm. on Finance*, 99th Cong., 2d Sess. (1986); *Medicare Reimbursement for Physician Services: Hearings Before the House Subcomm. on Health of the Comm. on Ways and Means*, 99th Cong., 2d Sess. (1986); *Medicare Physicians Payment Options: Hearings Before the Senate Special Comm. on Aging*, 98th Cong., 2d Sess. (1984); *Office of Technology Assessment, Payment for Physician Services: Strategies for Medicine* (1984); Jencks & Dobson, *supra* note 47; Burney, Hickman, Paradise & Schieber, *Medicare Physician Payment, Participation, and Reform*, HEALTH AFFAIRS 5 (Winter 1984); Fox, *Physician Reimbursement Under Medicare: An Overview and a Proposal for Area-Wide Physician Incentives*, and Hadley, *Critique of Peter Fox's Physician Reimbursement Under Medicare: An Overview and a Proposal for Area-Wide Physician Incentives*, reprinted in STAFF OF HOUSE COMM. ON WAYS AND MEANS, 98TH CONG., 2D SESS., PROCEEDINGS OF THE CONFERENCE ON THE FUTURE OF MEDICARE, 108-28 (1984). See generally, Law & Ensinger, *Negotiating Physicians' Fees: Individual Patients or Society? (A Case Study in Federalism)*, 61 N.Y.U. L. REV. 1 (1986).

186. See Physician Payment Review Commission, Annual Report to Congress, *Medicare Physician Payment: An Agenda for Reform* (March 1, 1987).

187. *Medicare Beneficiary Appeals Process*, reprinted in *Technical Appendixes to ProPAC Report*, *supra* note 48, Appendix C, at 163.

fact that Medicare is an enormous program serving 30 million beneficiaries spread throughout the United States and its territories, as well as a decentralized program with numerous public and private organizations, i.e., HCFA, fiscal intermediaries, carriers, PRO's, hospitals and other institutions, and physicians, executing various administrative and service responsibilities under the program. This article is concerned only with the appeals processes that are available for Medicare beneficiaries and providers in disputes over coverage of and payment for Medicare benefits. Consequently, this chapter describes only these appeals processes.

A. Historical Development of the Medicare Appeals System

1. The Original Appeals System

In designing the Medicare program in 1965, Congress determined that administrative review by HEW and judicial review would only be accorded to beneficiaries having disputes as to entitlement to benefits or the amount of benefits under Part A exceeding a certain sum.¹⁸⁸ The Medicare statute provided further that section 205(b)¹⁸⁹ and section 205(g)¹⁹⁰ of the Social Security Act, which govern administrative and judicial review for other appeals under the Social Security Act, would apply to these Medicare appeals.¹⁹¹

Congress did not authorize comparable administrative or judicial review for provider payment disputes under Part A nor offer any rationale for this decision in the legislative history. Pursuant to section 1872 of the Social Security Act, section 205(h) applied to provider appeals.¹⁹² Thus, in the early years of the Medicare program, fiscal in-

188. Social Security Amendments of 1965, § 102(a) (codified as amended at 42 U.S.C. § 1395ff(b) (Supp. II 1984)). The House bill proposed an amount in controversy for administrative and judicial review of \$1,000 while the Senate amendment proposed a \$100 threshold. The conference committee determined to allow administrative appeals for amounts in controversy exceeding \$100 and judicial review for amounts of \$1,000 and above. H.R. REP. NO. 682, 89th Cong., 2d Sess. 46 (1966).

189. Social Security Act, § 205(b), 42 U.S.C. § 405(b) (Supp. II 1984).

190. Social Security Act, § 205(g), 42 U.S.C. § 405(g) (Supp. II 1984).

191. Social Security Amendments of 1965, § 102(a) (codified as amended at 42 U.S.C. § 1395ff(b) (Supp. II 1984)).

192. Social Security Amendments of 1965, § 102(a) (codified as amended at 42 U.S.C. § 1395ii (Supp. II 1984)). Section 205(h) provides:

The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

intermediaries heard all appeals of provider payment disputes, and no subsequent review by the Secretary of HEW or the federal courts was available.

Congress also did not authorize administrative or judicial review of coverage and payment determinations under Part B for either beneficiaries or providers. Rather, Congress simply provided that carriers, as part of their contractual responsibilities with HEW, would conduct fair hearings for beneficiaries in disputes over the carriers' coverage and payment determinations.¹⁹³ According to the Senate Finance Committee, this approach was justified because under Part B "claims will probably be for substantially smaller amounts than under Part A."¹⁹⁴ As with claims of providers under Part A, Part B claimants are also subject to section 205(h), with its bar to federal question jurisdiction pursuant to section 1872 of the Social Security Act.¹⁹⁵

2. *Early Concerns and Problems*

Several problems emerged with the appeals process shortly after the Medicare program began, which Congress specifically addressed in the Social Security Amendments of 1972. Many other concerns, such as the statutory preclusion of administrative and judicial review of Part B claims, did not precipitate congressional action until recently and will be discussed below. The two problems that Congress did address in the Social Security Amendments of 1972 are discussed below.

The Provider Reimbursement Review Board (PRRB). Providers, who were having substantial and complex disputes with fiscal intermediaries and the Medicare program over payment under the cost reimbursement system, objected to the informality of intermediary hearing proceedings and the lack of administrative or judicial review for the intermediary's final payment determination.¹⁹⁶ In 1972, the federal district court in *Coral Gables Convalescent Home, Inc. v. Richardson*¹⁹⁷ ruled that extant intermediary hearing procedures with no appeal to the Secretary

Social Security Act, § 205(h), 42 U.S.C. § 405(h) (1982 & Supp. II (1984)).

193. Social Security Amendments of 1965, § 102(a) (codified as amended at 42 U.S.C. § 1395u(c)(7) (Supp. II 1984)). This right to a fair hearing has been extended to providers who accept assignment of a beneficiary's Part B benefits.

194. S. REP. NO. 404, 89th Cong., 2d Sess. 55 (1965).

195. Social Security Amendments of 1965, § 102(a) (codified as amended at 42 U.S.C. § 1395ii (Supp. II 1984)).

196. See Homer & Platten, *Medicare Provider Reimbursement Disputes: An Analysis of the Administrative Hearing Procedures*, 63 GEO. L.J. 107 (1974) (written by prominent provider lawyers and identifies provider concerns with these administrative hearing procedures).

197. 340 F. Supp. 646 (S.D. Fla. 1972).

and no guidance through HEW regulations violated providers' rights to procedural due process. This court ordered the Secretary to promulgate any necessary regulations to correct these constitutional deficiencies, and the Secretary promulgated regulations accordingly.¹⁹⁸

Providers were particularly dissatisfied with the preclusion of judicial review of intermediary decisions in payment disputes. Some courts, compelled by the harshness of this statutory preclusion, found other grounds for federal question jurisdiction.¹⁹⁹ However, most courts refused to acknowledge federal jurisdiction in Medicare payment cases,²⁰⁰ especially after the Supreme Court's 1972 decision in *Weinberger v. Salfi*.²⁰¹ *Weinberger* clarified that section 205(h)'s bar to federal question jurisdiction applied to all payment claims under the Social Security Act even when the claimant raised an associated constitutional issue.²⁰²

Responding to these provider concerns and frankly stating that it had overlooked the resolution of provider disputes in originally designing the Medicare appeals system,²⁰³ Congress established the Provider Reimbursement Review Board (PRRB) in the Social Security Amendments of 1972 to adjudicate payment disputes arising between providers and intermediaries in cost reporting periods ending after June 30, 1973.²⁰⁴ Congress also authorized judicial review of PRRB decisions.²⁰⁵

Waiver of Liability. Beneficiaries had several concerns about coverage determinations under Part A and Part B in the early years of the Medicare program.²⁰⁶ The most serious problem resulted from HEW

198. See 37 Fed. Reg. 10,724 (codified at 20 C.F.R. §§ 405.490-499 (1974)).

199. *E.g.*, *Adams Nursing Home of Williamston, Inc. v. Mathews*, 548 F.2d 1077 (1st Cir. 1977); *Rothman v. Hospital Serv. of S. Cal.*, 510 F.2d 956 (9th Cir. 1975); *Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663 (2d Cir. 1973); *Aquavella v. Mathews*, 437 F.2d 397 (2d Cir. 1971).

200. *E.g.*, *Faith Hosp. Assoc. v. Blue Cross Hosp. Serv.*, 537 F.2d 294 (8th Cir. 1976), *cert. denied*, 429 U.S. 977 (1976); *St. Louis Univ. v. Blue Cross Hosp. Serv., Inc.*, 537 F.2d 283 (8th Cir. 1976), *cert. denied*, 429 U.S. 977 (1976); *South Windsor Convalescent Home, Inc. v. Mathews*, 541 F.2d 910 (2d Cir. 1976); *cf. MacDonald Foundation, Inc. v. Mathews*, 571 F.2d 328 (5th Cir. 1978), *cert. denied*, 739 U.S. 893 (1978).

201. 422 U.S. 749 (1975).

202. See Comment, *Federal Question Jurisdiction Over Medicare Provider Appeals After Weinberger v. Salfi: Toward a Principled Construction of the Statutory Bar*, 65 VA. L. REV. 1383 (1979).

203. S. REP. NO. 1230, 92d Cong., 2d Sess. 248 (1972); see *Homer & Platten*, *supra* note 196, at 119.

204. Social Security Amendments of 1972, § 243(a) (codified as amended at 42 U.S.C. § 1395oo (Supp. II 1984)).

205. Social Security Amendments of 1972, § 243(a) (codified as amended at 42 U.S.C. § 1395oo(a) (Supp. II 1984)).

206. See *Butler, Advocate's Guide to the Medicare Program*, 8 CLEARINGHOUSE

policies, precipitated by escalating costs and high utilization rates, interpreting statutory definitions of benefits more strictly and then denying coverage of and payment for services already provided on a retroactive basis.²⁰⁷ This was particularly a problem with skilled nursing benefits. In 1968 the Social Security Administration instructed fiscal intermediaries and carriers to define covered "skilled nursing services" more narrowly and proscribed "custodial care" more broadly to reduce the utilization of and, thus, the cost of skilled nursing home services for Medicare beneficiaries.²⁰⁸ Following these policy changes, fiscal intermediaries denied a large volume of skilled nursing home services on a retroactive basis, causing severe financial hardship for beneficiaries who thought Medicare would pay for their care and for providers that furnished expensive services with the expectation of being paid.²⁰⁹

Congress, concerned about these retroactive denials and the implications for beneficiaries, specifically sought to mitigate the harsh and unfair results of these practices. In the Social Security Amendments of 1972, Congress authorized the Medicare program to waive the liability of beneficiaries or providers for any services provided that were subsequently determined not to be covered Medicare benefits according to medical criteria, i.e., not medically necessary or constituting custodial care, if they did not know or had no reason to know that the services were not covered.²¹⁰

B. *The Present Medicare Appeals System*

Analytically, it is useful to think of the present Medicare appeals system for coverage and payment disputes as a tree, with the first division separating appeals procedures for Part A from those for Part B. For Part A, the major branch divides into two branches: one for beneficiary appeals of coverage determinations²¹¹ and one for provider ap-

REV. 831 (1974); Butler, *Medicare Appeal Procedures: A Constitutional Analysis*, 70 NW. U.L. REV. 139 (1975). These articles, by a recognized advocate of beneficiary rights, review the objections to the early Medicare appeals procedures from the beneficiary's perspective.

207. Butler, *Advocates Guide*, *supra* note 206, at 836-837.

208. Part A Intermediary Letter No. 328 (June 1968); 20 C.F.R. §§ 405.125-.127 (1974); see Butler, *Advocate's Guide*, *supra* note 206, at 837.

209. *Id.*

210. Social Security Amendments of 1972 § 213(a), (codified as amended at 42 U.S.C. § 1395pp (Supp. II 1984)).

211. Beneficiaries may appeal adverse eligibility determinations under Part A and Part B. Social Security Act § 1869, 42 U.S.C. § 1395ff (Supp. II 1984). Appeals may be taken to an administrative law judge in the Social Security Administration and, ultimately, to federal court, and no specified amount in controversy is required. Providers under Part A may also appeal adverse decisions regarding their eligibility to par-

peals of payment determinations. The Part B branch does not divide because there is a combined process for beneficiary appeals of both coverage and payment determinations, with providers having appeal rights only if they accept assignment of Part B benefits from beneficiaries.²¹² Included in the branch for beneficiary appeals under both Part A and Part B is an appeals process to determine whether the Medicare program should waive the liability of the beneficiary and/or the provider for a service determined not to be a covered benefit under the Medicare program on medical grounds.²¹³

1. Beneficiary Appeals Under Part A

For skilled nursing and home health services, the fiscal intermediary makes the initial coverage and payment determination regarding Medicare benefits provided a beneficiary, including whether the services are covered according to medical criteria, i.e., whether the services were medically necessary or constituted custodial care.²¹⁴ Beneficiaries may obtain reconsideration of this initial determination from HCFA.²¹⁵ PRO's, rather than fiscal intermediaries, make the initial determination that a hospital service is not a covered Medicare benefit according to medical criteria.²¹⁶ Congress has effectively delegated the authority to determine coverage of inpatient hospital benefits to PRO's, although HCFA has taken the position that the PRO determination on coverage does not supersede HCFA's authority to enforce coverage provisions of the Social Security Act.²¹⁷

After receiving a notice of initial determination of benefits and payment, the first step in a beneficiary's appeal of a dispute over coverage of or, less often, payment for Medicare benefits is reconsideration by the fiscal intermediary in the case of skilled nursing and home health

participate in the Medicare program. Social Security Act § 1869, 42 U.S.C. § 1395ff (Supp. II 1984); 42 C.F.R. §§ 405.1501-.1595 (1986).

212. See *infra* notes 277-301 and accompanying text (explaining appeals process under Part B).

213. There are no appeal rights for any other party besides a beneficiary or provider affected by a HCFA coverage decision, even those coverage decisions of HCFA, fiscal intermediaries or carriers regarding whether to pay for new medical technologies and procedures. See *supra* notes 187-210 and accompanying text (discussing original appeals system). Health equipment manufacturers have pressed for creation of an appeals process for this type of global coverage decision. See Health Industry Manufacturers Association, *Recommendations of the HIMA Product Introduction Coordination Task Force* (May 29, 1986).

214. 42 C.F.R. §§ 405.704(b)(11), (12) (1986).

215. *Id.* §§ 405.710-.717.

216. *Id.* §§ 405.710-.717.

217. 42 C.F.R. § 466.86(c) (1986).

benefits, or by the PRO in the case of hospital benefits.²¹⁸ PRO's handle all appeals of their initial determinations on benefit and coverage issues for beneficiaries and providers.²¹⁹ The reconsideration is basically a paper review at which the beneficiary is generally not present or represented by counsel. In the PRO reconsideration procedure, the beneficiary, physician, or hospital may submit additional information and examine the material on which the PRO based its initial determination, although the PRO may not disclose the record of the PRO deliberation or the identity of the decisionmakers.²²⁰ The decisionmaker in the reconsideration must be a physician who did not make the initial determination.²²¹

Social Security Act section 1869(b) authorizes administrative review of the determinations by fiscal intermediaries on coverage of benefits of \$100 or above and judicial review of claims of \$1,000 or above.²²² Fiscal intermediaries, except in the case of hospital benefits, handle appeals of disputes over benefits under \$100. TEFRA expressly gave PRO's the responsibility of handling beneficiary appeals of hospital benefit coverage determinations made according to medical criteria.²²³

Administrative review before an administrative law judge (ALJ) in the Social Security Office of Hearings and Appeals is available for ben-

218. See *id.* §§ 405.710-717 (providing for fiscal intermediary reconsideration process); *id.* §§ 473.16-.38 (providing for PRO reconsideration process).

219. Social Security Act, §§ 1862(g), 1154(a)(2), 42 U.S.C. §§ 1395y(g), 1320c-3(a)(2) (Supp. II 1984); 42 C.F.R. §§ 466.83-.86 (1986); see *Medicare Beneficiary Appeals Processes, reprinted in Technical Appendixes to the ProPAC Report, supra* note 48, Appendix C, at 162. Before making an initial denial determination or change in a DRG classification, the PRO must notify the provider and the beneficiary's physician and allow them an opportunity to discuss the matter with the PRO's physician advisor. 42 C.F.R. § 466.93 (1986). Once the PRO has made a determination to deny coverage on medical grounds, it is required to give notice of this denial to the beneficiary, the attending physician, the provider and the fiscal intermediary. *Id.* § 466.94. This notice must also advise the beneficiary of the available right for reconsideration by the PRO. *Id.* § 466.94(c).

220. *Id.* § 473.24.

221. *Id.* § 473.28.

222. Social Security Act, § 1869(b), 42 U.S.C. § 1395ii(b) (Supp. II 1984)). This section provides:

Any individual dissatisfied with any determination under subsection (a) as to . . . (C) the amount of benefits under part A . . . shall be entitled to a hearing thereon by the Secretary to the same extent as provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

Id.; see also 42 C.F.R. § 405.704 (1986).

223. Tax Equity and Fiscal Responsibility Act of 1982, §§ 142, 143 (codified as amended at 42 U.S.C. §§ 1395y, 1320c-3 (Supp. II 1984)). The only coverage appeals regarding hospital services that fiscal intermediaries now handle are those regarding technical determinations of whether a service is a covered benefit under the statute or regulations. 42 C.F.R. § 466.86(c)(2) (1986).

eficiary appeals under Part A of \$100 and above.²²⁴ In Fiscal Year 1985, there were 3,927 requests for ALJ hearings for both Part A coverage determinations and some Medicare eligibility issues — a decline of 4% from ALJ hearing requests in Fiscal Year 1984.²²⁵ A beneficiary may appeal the final decision of the PRO in a hospital medical coverage appeal to an ALJ in SSA if the amount in controversy is \$200 or more.²²⁶ For all other Part A coverage issues, the requisite amount in controversy for an ALJ hearing is \$100 or more.²²⁷

The ALJ proceeding is the first opportunity for an oral hearing at which a beneficiary may personally appear and plead his case, although an oral hearing may be waived.²²⁸ The role of the ALJ in Part A coverage appeals, as in other Social Security program appeals, is that of a non-partisan examiner rather than a judge in an adversarial hearing.²²⁹ In these proceedings, HHS is not represented by counsel, but the individual claimant may be represented by counsel if desired.²³⁰ The ALJ has primary responsibility for developing the record, in contrast to conventional adjudicative proceedings in which counsel for the parties has this responsibility.²³¹ There is also an expedited appeals process for cases where the beneficiary has claimed, and HHS agrees, that the only factor preventing a favorable decision for the beneficiary is a statutory or regulatory provision that the beneficiary maintains is unconstitutional.²³²

A claimant dissatisfied with the ALJ's decision may request review by the SSA Appeals Council in its Office of Hearings and Appeals.²³³ The Appeals Council may also review and reverse an ALJ decision on its own motion.²³⁴ The Appeals Council may review a case if an abuse

224. Social Security Act §§ 1869(b)(1)(C), (b)(2), 42 U.S.C. § 1395ff(b)(1)(C), (b)(2) (Supp. II 1984); 42 C.F.R. §§ 405.720, 422.203-.210 (1986).

225. Social Security Administration, *Operational Report of the Office of Hearings and Appeals* 28 (1985).

226. Social Security Act, § 1155, 42 U.S.C. § 1320c-4 (Supp. II 1984); 42 C.F.R. § 473.10 (1986).

227. Social Security Act, § 1869(b)(2), 42 U.S.C. § 1395ff(b)(2) (Supp. II 1984); 42 C.F.R. § 405.720 (1986).

228. 20 C.F.R. §§ 404.944, 404.948 (1986).

229. See *Richardson v. Perales*, 402 U.S. 389 (1971) (upholding investigatory model for ALJ conduct in Social Security disability hearings); see also J. MASHAW, *SOCIAL SECURITY HEARINGS AND APPEALS* (1978).

230. 42 C.F.R. §§ 404.1700-.1710 (1986).

231. *Id.* § 404.951.

232. *Id.* §§ 405.718-.718e (1986).

233. *Id.* § 405.724; see 20 C.F.R. § 405.967 (1986) (providing for skilled nursing facility and home health agency appeals); 42 C.F.R. §§ 473.40, 473.46(a) (1986) (providing for hospital appeals).

234. 20 C.F.R. § 404.969 (1986).

of discretion by the ALJ or an error of law is alleged, the record indicates that the decision is not supported by substantial evidence, or there is a broad policy or procedural issue that may affect the general public interest.²³⁵ HCFA also may review and refer to the Appeals Council, under its reopening provisions,²³⁶ any ALJ or Appeals Council decision that it believes is contrary to the Medicare statute and regulations.

For skilled nursing and home health agency appeals, a beneficiary may seek judicial review of a final decision by the Secretary if the amount in controversy is \$1,000 or more.²³⁷ For a coverage decision on hospital services decided by a PRO, a beneficiary may seek judicial review of a final decision by the Secretary if the amount in controversy is at least \$2,000.²³⁸ To obtain judicial review for all Part A beneficiary coverage appeals, suit must be brought within 60 days in the federal district court for the judicial district in which the claimant resides, where the individual, institution, or agency has a principle place of business, or in the United States District Court for the District of Columbia.²³⁹

2. Provider Appeals Under Part A

Provider appeals under Part A are adjudicated by the PRRB if the amount in controversy is \$10,000 or more and by the provider's fiscal intermediary if the amount in controversy is between \$1,000 and \$10,000.²⁴⁰ All institutional providers paid under Part A, including skilled nursing facilities and home health agencies, can appeal to the PRRB.²⁴¹ In 1984 approximately 1,500 appeals were made to the PRRB.

The Social Security Amendments of 1983 expressly provided that hospital payment disputes would be handled under existing appeals procedures but limited with respect to the issues that could be appealed.²⁴² Congress specifically intended that hospital appeals over pay-

235. *Id.* § 404.970 (1986).

236. *Id.* §§ 404.987-988; 42 C.F.R. § 405.750 (1986).

237. Social Security Act, § 1869(b)(2), 42 U.S.C. § 1395ff(b)(2) (Supp. II 1984); 42 C.F.R. § 405.730 (1986).

238. Social Security Act, § 1155, 42 U.S.C. § 1320c-4 (Supp. II 1984); 42 C.F.R. § 473.46(b) (1986).

239. Social Security Act, § 205(g), 42 U.S.C. § 405(g) (Supp. II 1984).

240. Social Security Act, § 1878(a), 42 U.S.C. § 1395oo(a) (Supp. II 1984); 42 C.F.R. §§ 405.1801-1890 (1986). In order for an intermediary to provide a hearing, the amount in controversy must be at least \$1,000. *Id.* § 405.1811.

241. Social Security Act, § 1878(a), 42 U.S.C. § 1395oo(a) (Supp. II 1984); 42 C.F.R. § 405.1801(b)(1) (1986).

242. Social Security Amendments of 1983, § 602(h) (codified as amended at 42 U.S.C. §§ 1395oo(g)(2), 1395ww(d)(7) (Supp. II 1984). The Social Security Amend-

ment disputes be heard by the PRRB, as the House Ways and Means Committee explained:

Your Committee's bill would provide for the same procedures for administrative and judicial review of payments under the prospective payment system as is currently provided for cost-based payments. In general, the same conditions, which now apply for review by the PRRB and the courts, would continue to apply.²⁴³

Thus, Congress amended section 1878 of the Social Security Act to accord the PRRB jurisdiction to hear challenges to the "final determination of the Secretary as to the amount of payment" under the prospective payment system.²⁴⁴

The PRRB. The PRRB, comprised of five members knowledgeable in health care financing who are appointed for three year terms by the Secretary,²⁴⁵ adjudicates payment disputes between providers and fiscal intermediaries²⁴⁶ if the amount in controversy is at least \$10,000 and the provider files a request for hearing within the prescribed time period.²⁴⁷ A group of providers may bring a joint appeal if the disputed issues involve a common question of fact or interpretation of law or regulation and the aggregate amount in controversy is \$50,000 or more.²⁴⁸ The PRRB has jurisdiction to adjudicate the intermediary's determination of total reimbursement for services to Medicare beneficiaries and the intermediary's final determination of payment under section 1886(b) and section 1886(d) of the Social Security Act.²⁴⁹ The PRRB may also hear appeals regarding the intermediary's failure to furnish a provider with a final determination of the Medicare payment

ments of 1983 preclude administrative and judicial review of: (1) the establishment of DRG's, the methodology for classifying patient discharges into DRG's, and the appropriate weighting factors for DRG's; and (2) the factor used in a hospital's current payment formula to ensure compliance with the so-called "budget neutrality" requirement that the prospective payment system result in total Medicare payments to hospitals in FY 1984 and FY 1985 equal to what would have been payable under the previous Medicare payment methodology in those fiscal years.

243. H.R. REP. NO. 25, 98th Cong., 1st Sess. 143 (1983); *see also* S. REP. NO. 23, 98th Cong., 1st Sess. 57 (1983).

244. Social Security Amendments of 1983, § 602(h)(1) (codified as amended at 42 U.S.C. § 1395oo(a)(1) (Supp. II 1984).

245. Social Security Act, § 1878(h), 42 U.S.C. § 1395oo(h) (Supp. II 1984); 42 C.F.R. § 405.1845 (1986). Two board members must be representative of providers, and a quorum of three members, including at least one provider representative, is required for a PRRB decision. *Id.*

246. The parties before a Board hearing are the provider and its fiscal intermediary. Social Security Act, § 1878(a), 42 U.S.C. § 1395oo(a) (Supp. II 1984).

247. *Id.*

248. Social Security Act, § 1878(b), 42 U.S.C. § 1395oo(b) (Supp. II 1984); 42 C.F.R. § 405.1837 (1986).

249. Social Security Act, §§ 1886(b), (d); 42 U.S.C. §§ 1395ww(b), (d) (Supp. II 1984).

amount on a timely basis.²⁵⁰ The PRRB has no authority to adjudicate coverage issues²⁵¹ or the validity of Medicare regulations or program directives.²⁵² In its decisions, the Board must observe the statute and regulations as well as HCFA rulings and must "afford great weight" to interpretative rules and other HCFA directives.²⁵³

Hearings before the PRRB are formal adjudicative hearings. A provider may be represented by counsel, may conduct prehearing discovery,²⁵⁴ and at the hearing may cross-examine witnesses.²⁵⁵ The Board has subpoena power to compel attendance and testimony of witnesses as well as the production of documents and other evidence.²⁵⁶ If a party raises an issue of HHS policy that is interpretative of the Medicare statute and regulations, the Board must promptly notify HCFA.²⁵⁷ Expedited review is available for issues of law over which the Board has jurisdiction but no authority to decide.²⁵⁸ A PRRB decision must be based on the hearing record and be supported by substantial evidence when the record is viewed as a whole.²⁵⁹ The Board's decision is final.²⁶⁰

The Secretary has authority to reverse, affirm, or modify the Board's decision on his own motion and within 60 days after the provider is notified of the Board's decision.²⁶¹ The criteria for reversal are that the

250. Social Security Act, § 1878(a)(1)(C), 42 U.S.C. § 1395oo(a)(1)(C) (Supp. II 1984).

251. Social Security Act, § 1878(g)(1), 42 U.S.C. § 1395oo(g)(1) (Supp. II 1984); 42 C.F.R. § 405.1873 (1986).

252. 42 C.F.R. § 405.1873 (1986); see HCFA Admr. Dec. (Feb 15, 1980), *rev'd*, PRRB Dec. No. 79-D95 (Dec. 17, 1979). This Deputy Administrator's decision was affirmed in *Indiana Hospital Association v. Schweiker*, 544 F. Supp. 1167 (S.D. Ind. 1982), *aff'd sub nom. St. Francis Hosp. Center v. Heckler*, 714 F.2d 822 (7th Cir. 1983), *cert. denied*, 465 U.S. 1022 (1980). Basically, the PRRB has authority to affirm, modify or reverse a final determination by the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report. Social Security Act, § 1878(d), 42 U.S.C. § 1395oo(d) (Supp. II 1984); 42 C.F.R. § 405.1869 (1986).

253. *Id.* § 405.1867.

254. *Id.* § 405.1851.

255. Social Security Act, § 1878(c), 42 U.S.C. § 1395oo(c) (Supp. II 1984); 42 C.F.R. §§ 405.1853-.1855 (1986).

256. *Id.* § 1857.

257. *Id.* § 405.1863.

258. Social Security Act, § 1878(f), 42 U.S.C. § 1395oo(j) (Supp. II 1984); 42 C.F.R. § 405.1842 (1986). This procedure has been used 160 times since its creation in 1981.

259. Social Security Act, § 1878(d), 42 U.S.C. § 1395oo(d) (Supp. II 1984); 42 C.F.R. § 1871(a) (1986).

260. Social Security Act, § 1878(f)(1), 42 U.S.C. § 1395oo(f)(1) (Supp. II 1984); 42 C.F.R. § 1871(b) (1986).

261. Social Security Act, § 1878(f)(1), 42 U.S.C. § 1395oo(f)(1) (Supp. II 1984). The Secretary has delegated this authority to the HCFA Deputy Administrator. 42

Board has made an erroneous interpretation of the law, regulations, or a HCFA ruling; the decision is not supported by substantial evidence; the case presents a significant policy issue that might lead to issuance of a HCFA ruling or other directive; the Board has incorrectly assumed or denied jurisdiction; or the decision needs clarification, amplification, or an alternative legal basis.²⁶² As will be discussed below, this review authority has been a source of serious provider concern because of the high rate of reversals of PRRB decisions by the Secretary.²⁶³

A provider has the right to judicial review of any final decision of the Board or subsequent secretarial action on that decision.²⁶⁴ Suit must be brought within 60 days of receipt of the Secretary's final decision in the federal district court of the judicial district in which the provider is located or in the District Court for the District of Columbia.²⁶⁵ A group appeal of several providers may be brought in the judicial district in which the greatest number of providers are located or in the District Court for the District of Columbia.²⁶⁶

It has yet to be determined how extensive or influential the role of the PRRB will be under the prospective payment system. The Board has not yet begun to hear hospital appeals of issues arising under the prospective payment system because of HCFA's requirement, discussed below, that the intermediary issue a notice of program reimbursement before a hospital may initiate an appeal to the PRRB.²⁶⁷ The PRRB still hears appeals of home health agencies and skilled nursing facilities as well as psychiatric and rehabilitation hospitals that are not paid under the prospective payment system.²⁶⁸ The PRRB also retains jurisdiction over a wide variety of issues for hospitals under the prospective payment system, including allowable hospital costs for the base year period; capital and educational costs; the status of hospitals or their components that is dispositive in determining whether or not the hospital or component is paid under the prospective payment system; and the applicability of exemptions, exceptions, and adjustments, such as

Fed. Reg. 57,351 (1977).

262. 42 C.F.R. § 405.1875(c) (1986).

263. *Infra* notes 451-462 and accompanying text.

264. Social Security Act, § 1878(f)(1), 42 U.S.C. § 1395oo(f)(1) (Supp. II 1984). It should be noted that there is no express authorization in the Social Security Act or regulations thereunder authorizing judicial review of provider payment disputes under \$10,000.

265. *Id.*

266. *Id.*

267. *See infra* notes 430-436 and accompanying text (discussing jurisdiction of PRRB).

268. *See Owens, The PRRB Lives On As an Appeal Mechanism for Healthcare Providers*, HEALTH CARE FIN. MGMT. 36 (1986).

those available for sole community hospitals and cancer hospitals.²⁶⁹ It is expected that these latter two issues will generate a considerable volume of appeals and litigation because of the significant financial ramifications for hospitals of such status determinations.²⁷⁰

The PRRB also has a considerable backlog of hospital appeals on issues arising under the hospital cost reimbursement system, i.e., allocations for labor, delivery room and malpractice insurance costs.²⁷¹ However, the number of appeals before the PRRB has increased considerably since 1981. PRRB appeals increased 80% between 1981 and 1982, remained constant the following year, and increased 40% between 1984 and 1985. But irrespective of what transpires under the prospective payment system, the Board anticipates that it will continue to hear a high volume of hospital appeals well beyond 1987, as well as a rising volume of home health agency appeals and skilled nursing facility appeals for an indefinite period.²⁷²

PRO Appeals for Hospitals. For hospitals, PRO's also adjudicate certain coverage issues related to payment arising under the prospective payment system. These include (1) disputes over outliers (cases that greatly exceed the length of stay and/or the estimated costs of the DRG in which the outlier case is assigned); and (2) errors in DRG coding for a particular case.²⁷³ HCFA adopted this approach, maintaining that the entity that makes the initial determination should hear the appeal.²⁷⁴ HCFA has also decided that the "waiver of liability" regulations will govern hearing and appeals if the PRO denies an entire stay or a "day" or "cost" outlier under section 1862(a)(1) or section 1861(a)(9) of the Social Security Act because services rendered were not medically necessary or reasonable or did not constitute custodial care.²⁷⁵ If the provider is dissatisfied with a PRO determination, it may seek a reconsideration by the PRO; however, the provider is not entitled to further administrative or judicial review of the PRO determination.²⁷⁶

269. See Owens, *supra* note 268, at 36-40; Clinton, *Provider Appeals Route Evolving Under the Medicare Prospective Payment System*, HEALTH L. VIGIL 19-24 (Nov. 29, 1985); Clinton, *PRRB Appeals Evolving Under PPS*, HEALTH LAW 1, 14-15 (Winter 1985).

270. See Owens, *supra* note 268.

271. See Owens, *supra* note 268.

272. See Clinton, *supra* note 269, at 19.

273. Preamble to Interim Final Rule, 48 Fed. Reg. 39,740, 39,785-786 (1983).

274. *Id.* at 39,785.

275. *Id.* at 39,784; see also 42 C.F.R. §§ 405.330-.332 (1986).

276. Social Security Act, § 1155, 42 U.S.C. § 1320c-4 (Supp. II 1984).

3. Appeals Under Part B

In the Social Security Amendments of 1965, Congress specifically precluded administrative and judicial review for beneficiary and provider disputes arising under Part B of the Medicare program on the assumption that the amounts involved in Part B claims would be small and, therefore, elaborate appeals procedures would be unnecessary.²⁷⁷ The only provision for appeals regarding Part B benefits that Congress made was a requirement in each carrier contract that the carrier:

[E]stablish and maintain procedures pursuant to which an individual enrolled under this part [Part B] will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is \$100 or more, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy.²⁷⁸

These fair hearing appeal procedures are available to any beneficiary and to any provider who has accepted assignment of a beneficiary's claim for Part B benefits.²⁷⁹

Upon making an initial determination of the coverage and amount of Medicare benefits, the carrier issues the "Explanation of Medicare Benefits" (EOMB) which specifies that the beneficiary and his assignee, i.e., the provider who accepts assignment, is entitled to a review of the carrier's initial determination.²⁸⁰ In this review determination, the carrier must make a separate determination affirming or revising the initial determination.²⁸¹ The notice of this review determination must expressly state the basis for the determination and advise the beneficiary of the right to a fair hearing if the amount in controversy is \$100 or more.²⁸² In 1984 carriers received 3.2 million requests for Part B review determinations and, of the 3 million processed to completion, 57% reversed the initial determination at an average cost per claim of \$118 and an aggregate cost of \$205 million.²⁸³

277. *Supra* notes 193-95 and accompanying text.

278. Social Security Act, § 1842(b)(3)(C), 42 U.S.C. § 1395u(b)(3)(C) (Supp. II 1984); see 42 C.F.R. § 405.801 (1986). In *Gray Panthers v. Schweiker*, 652 F.2d 146 (D.C. Cir. 1980), the United States Court of Appeals for the District of Columbia Circuit ruled that procedural due process required more formal hearing procedures and additional protections for beneficiaries in cases of disputed claims of less than \$100 than those accorded under a carrier's paper review of its initial determination on the claim.

279. Social Security Act, § 1842(b)(3)(C), 42 U.S.C. § 1395u(b)(3)(C) (Supp. II 1984); 42 C.F.R. § 405.801 (1986).

280. *Id.* § 405.807.

281. *Id.* § 405.810.

282. *Id.* § 405.811.

283. Congressional Research Service, *Medicare Appeals: Background Paper* (Oct.

The fair hearing for claims of \$100 or more is an oral hearing conducted by a hearing officer selected by the carrier.²⁸⁴ At a fair hearing, the hearing officer may be disqualified if "prejudiced or partial with respect to any party" or has "any interest in the matter before him."²⁸⁵ The regulations expressly provide that the fact that a hearing officer is an employee of the carrier may not serve as "prima facie cause for disqualification,"²⁸⁶ and as a matter of fact, many hearing officers are carrier employees. The regulations do allow a party to challenge the hearing officer on bias grounds.²⁸⁷ In 1984 carriers received about 30,000 requests for fair hearings and, of those processed to completion, 63% were decided in favor of the beneficiary at an average cost per claim of \$439 and an aggregate cost of \$5.8 million.²⁸⁸

At the fair hearing, the parties and anyone else the hearing officer deems necessary may appear, and the parties may be represented by counsel.²⁸⁹ Parties may present evidence, examine all witnesses, make oral argument, and submit briefs.²⁹⁰ A record is made and is available upon request to the parties and HCFA.²⁹¹ The hearing officer's decision must be based on the record, be in writing, and contain findings of fact and a statement of reasons for the decision.²⁹² The decision is final unless reopened and modified as provided in the regulations.²⁹³

In the Omnibus Budget Reconciliation Act of 1986, Congress established administrative review before an administrative law judge of the carrier's determination on a Part B claim of \$500 or more.²⁹⁴ Judicial review is available for claims of \$1000 and above.²⁹⁵ An important limitation, however, exists on issues for which administrative and judicial review is available. Specifically, HHS's decisions on whether a service

1985), reprinted in *Senate Finance Comm. Hearings on Medicare Appeals Provisions*.

284. 42 C.F.R. § 405.830 (1986).

285. *Id.* § 405.824.

286. *Id.* § 405.824.

287. *Id.* § 405.824.

288. Congressional Research Service, *Medicare Appeals: Background Paper* (Oct. 1985), reprinted in *Senate Finance Comm. Hearings on Medicare Appeals Provisions* 16.

289. 42 C.F.R. § 405.830 (1986).

290. *Id.* § 405.830.

291. *Id.* § 405.833.

292. *Id.* § 405.834.

293. *Id.* § 405.841.

294. Omnibus Budget Reconciliation Act of 1986, § 9341 (amending Social Security Act, § 1869, 42 U.S.C. § 1395ff (1982)). The statute requires that the Secretary promulgate regulations to allow two or more claims to be aggregated if the claims involve similar or related services to the same individual or common issues of law and fact arising from services furnished to different individuals. *Id.* This later provision permits physicians to appeal comparable claims for groups of patients.

295. *Id.*

or procedure is a covered benefit under the Medicare program shall not be reviewed by any administrative law judge.²⁹⁶ Furthermore, a reviewing court cannot overturn a national coverage decision on grounds that it failed to comply with requirements of the Administrative Procedure Act.²⁹⁷ For making these essentially medical decisions with HHS, Congress referred to the existent process to justify its position:

The process used by the Secretary in making such determinations, including the role of the National Center for Health Services Research and Health Care Technology Assessment, is designed to assure consultation with the scientific and medical community and the general public. If that process is adhered to, the further procedure for publishing proposed and final regulations in the Federal Register does not seem essential.²⁹⁸

Congress may have been persuaded to adopt this approach because of several challenges to national coverage determinations on grounds that they were substantive rules that failed to comply with the notice and comment procedures of informal rulemaking under the Administrative Procedure Act.²⁹⁹ If, in reviewing national coverage determinations, a court finds the record is inadequate to support the validity of the national coverage determination, it must remand the matter to the Secretary of HHS for additional proceedings to supplement the record before the court is authorized to rule on the coverage determination.³⁰⁰ Congress also provided that regulation or program instruction pertaining to Part B payment methodologies promulgated before January 1, 1981 would not be subject to judicial review.³⁰¹

4. *Waiver of Liability Appeals*

An important but distinct part of the benefit coverage determination under both Part A and Part B is the determination of whether the beneficiary or the provider should be financially liable for services that are determined to be not covered according to the medical criteria because the services are medically unnecessary, not provided in the appropriate

296. Omnibus Budget Reconciliation Act of 1986, § 9341 (amending Social Security Act, § 1869, 42 U.S.C. § 1395ff (1982)).

297. 5 U.S.C. §§ 551 et seq. (1982 & Supp. III 1985).

298. H.R. REP. NO. 1012, 99th Cong., 2d Sess. 350-51 (1986).

299. See, e.g., *Linoz v. Heckler*, 800 F.2d 871, 877 (9th Cir. 1986) (explaining substantive rules are subject to notice and comment rulemaking); *Vorster v. Secretary*, No. 84-9700-ER (C.D. Cal. June 26, 1986); *Griffith v. Bowen*, No. 86-2556-Y (D. Mass. 1986).

300. Omnibus Budget Reconciliation Act of 1986, § 9341 (amending Social Security Act, § 1869, 42 U.S.C. § 1395ff (1982)).

301. *Id.*

setting, or constitute custodial care.³⁰² Waiver of liability determinations are generally made at the same time as coverage determinations, which are based on medical criteria. Thus, the PRO makes the waiver of liability determinations for hospital benefits; fiscal intermediaries make the waiver of liability determinations for skilled nursing and home health benefits; and carriers make these determinations for Part B services.³⁰³

A waiver of liability may apply where the beneficiary and/or the provider had no reason to know that the services would not be covered. In these cases, the Medicare program absorbs the cost of the uncovered services, although the provider and beneficiary are then on notice for the future that such services are not covered.³⁰⁴ As explained above, Congress adopted this waiver of liability policy in the Social Security Amendments of 1972 to address provider and beneficiary concerns about unpredictable and often inconsistent retroactive denials of coverage by fiscal intermediaries and carriers.³⁰⁵

With respect to beneficiaries, there is a strong presumption that the beneficiary did not know that the services in question were excluded from coverage, thus constituting a waiver of liability that can be overcome only by demonstrating that the beneficiary knew, or had reason to know, that the services in question were not covered.³⁰⁶ These presumptions in favor of the beneficiary are quite strong, and several courts have reiterated the great burden HHS has in demonstrating that the beneficiary had knowledge that past, and even future, services were not covered.³⁰⁷

The criteria for whether the provider had knowledge that the services were uncovered are less strict. If the intermediary or the institution's utilization review committee told the provider that the services or simi-

302. Social Security Act, § 1879, 42 U.S.C. § 1395pp (Supp. II 1984); 42 C.F.R. §§ 405.330-332 (1986).

303. 42 C.F.R. § 405.710 (1986) (Part A coverage issues for skilled nursing and home health services); *id.* § 473.16 (hospital services); *id.* § 405.807 (Part B coverage issues).

304. Social Security Act, § 1879(a), 42 U.S.C. § 1395pp(a) (Supp. II 1984).

305. Social Security Amendments of 1972, § 213(a) (codified as amended at 42 U.S.C. § 1395pp (Supp. II 1984)).

306. Social Security Act, § 1879(c), 42 U.S.C. § 1395pp(c) (Supp. II 1984); 42 C.F.R. § 405.332 (1986). In order to demonstrate that a beneficiary knew or had reason to know that items or services furnished to him were excluded from coverage, the beneficiary, or someone acting on his behalf, must have received written notice stating that the items or services were excluded from coverage. *Id.*

307. See, e.g., *Himmler v. Califano*, 611 F.2d 137 (6th Cir. 1979); *Walsh v. Secretary of U.S. Dept. of Health and Human Services*, 636 F. Supp. 358 (E.D.N.Y. 1986) (held against beneficiary due to receipt of written notice); *Malvasi v. Harris*, No. 79-CV-635 (N.D.N.Y. July, 30, 1980).

lar services were not covered, then the provider is deemed to have knowledge for purposes of denying a waiver of liability.³⁰⁸ As a practical matter, most waiver of liability issues concern the provider's, rather than the beneficiary's, liability for uncovered services. Until recently, HCFA had a procedure whereby providers under Part A were deemed to be entitled to a waiver of liability if the rate of coverage denials for the provider was below a certain percent. In March 1986, however, HCFA promulgated new rules on waiver of liability that discontinued this favorable presumption procedure and required that waiver of liability be determined on a case-by-case basis for all providers under Part A and Part B.³⁰⁹

The right to challenge a waiver of liability decision rests chiefly with the beneficiary and only secondarily with the provider. For Part A, a beneficiary may appeal the final decision of the fiscal intermediary or PRO (in the case of hospitals) on waiver of liability to an ALJ in the SSA Office of Hearings and Appeals if the amount in controversy is \$100 or more.³¹⁰ The beneficiary is entitled to reconsideration by the SSA Appeals Council³¹¹ and may seek judicial review of the final agency decision on waiver of liability if the amount in controversy is \$1,000 or more.³¹² Section 1879(d) permits the provider to appeal a coverage issue to an ALJ and federal district court where a waiver of liability is not granted for the provider, but only if the beneficiary decides not to appeal.³¹³

The waiver of liability requirement for hospitals is somewhat different. If the PRO determines that the waiver should apply to uncovered services, the hospital has no right to appeal even if it disagrees about the underlying coverage determination.³¹⁴ If the PRO determines that the care was unnecessary and denies the waiver because the hospital knew or should have known so, the hospital is entitled to a hearing before an ALJ in SSA on whether it had knowledge that care was not covered, but cannot challenge the substantive coverage decision upon which the denial of the waiver was predicated.³¹⁵ Hospitals may also seek judicial review for such decisions involving claims of \$2,000 or

308. 42 C.F.R. § 405.341 (1986).

309. 51 Fed. Reg. 6222 (1986) (to be codified at 42 C.F.R. § 405.336 (1986)).

310. Social Security Act, § 1867(d), 42 U.S.C. § 1395pp(d) (Supp. II 1984).

311. 42 C.F.R. §§ 405.727 and 405.967 (1986).

312. Social Security Act, § 1869(b)(2), 42 U.S.C. § 1395ff(b)(2) (Supp. II 1984); 42 C.F.R. § 405.730 (1986).

313. Social Security Act, § 1879(d), 42 U.S.C. § 1395pp(d) (Supp. II 1984). Judicial Review is available only for claims exceeding \$1000. *Id.*

314. Social Security Act, § 1155, 42 U.S.C. § 1320c-4 (Supp. II 1984).

315. *Id.*

more.³¹⁶

Under Part B, a beneficiary may appeal a review determination of the carrier on waiver of liability to a hearing officer selected by the carrier if the amount in controversy is \$100 or more.³¹⁷ If the provider is found liable for the service and the beneficiary does not exercise his appeal rights, the provider may request a hearing before the carrier.³¹⁸ Despite the establishment of administrative and judicial review of Part B claims in the Omnibus Budget Reconciliation Act of 1986,³¹⁹ Congress has not authorized administrative or judicial review of a carrier decision on a waiver of liability determination for Part B benefits.³²⁰ This anomalous situation may, however, result from a congressional oversight.

C. Recent Congressional Action on Medicare Appeals

With the implementation of the prospective payment system, Congress and HHS, as well as beneficiary and provider interest groups, have become quite concerned about the Medicare appeals system. Three factors have precipitated this concern.³²¹ First, there had been ongoing congressional concern about appeals under Part B as a result of reported underpayment by the Medicare program for Part B benefits, as documented in several reports of the General Accounting Office³²² and court challenges on the constitutionality of Part B hearing procedures.³²³ Second, there were reports that hospitals were discharging patients earlier and in a sicker condition as a direct result of the implementation of the prospective payment system and that many patients, wishing to remain in the hospital, had inadequate information about their appeals rights to protest such hospital actions.³²⁴ Third,

316. *Id.*

317. Social Security Act, § 1842(b)(3)(C), 42 U.S.C. § 1395u(b)(3)(C) (Supp. II 1984); 42 C.F.R. §§ 405.820, 405.823 (1986).

318. *Id.*

319. *See supra* notes 130-32 and accompanying text (discussing legislative reforms in the Omnibus Budget Reconciliation Act of 1986).

320. Social Security Act, § 1879(d), 42 U.S.C. § 1395pp(d) (Supp. II 1984).

321. *See* Congressional Research Service, *Medicare Appeals Background Paper*, reprinted in *Senate Finance Comm. Hearings on Medicare Appeals Provision*.

322. Government Accounting Office, *Reasonable Charge Reductions Under Part B of Medicare* (HRD-81-12 Oct. 22, 1980); Government Accounting Office, *More Action Needed to Reduce Beneficiary Underpayments* (HRD-81-126 Sept. 3, 1981); Government Accounting Office, *Medicare Part B Beneficiary Appeals Process* (HRD-85-79 June 28, 1985).

323. *See* *United States v. Erika, Inc.*, 456 U.S. 201 (1982); *Schweiker v. McClure*, 456 U.S. 188 (1982); *Gray Panthers v. Schweiker*, 652 F.2d 146 (D.C. Cir. 1980).

324. *See* *Senate Special Comm. on Aging, Hearings on Quality of Care Under Medicare's Prospective Payment; Sustaining the Quality of Health Care Under Cost*

early in 1985 provider and consumer organizations created a coalition specifically to pressure Congress for reforms of the Medicare appeals system.³²⁵

In 1985 several congressmen introduced legislation to reform the Medicare appeals system.³²⁶ These bills all provided for administrative and judicial review of Part B claims and some would have allowed providers to represent beneficiaries in appeals.

The COBRA Conference Committee, whose report was ultimately rejected by the House, adopted these Medicare appeals provisions and also adopted a requirement that a national coverage determination made pursuant to section 1862(a)(1)(A)³²⁷ by HCFA, after consultation with the Public Health Service and published in the *Medicare Coverage Issues Manual*,³²⁸ cannot be reversed on appeal. The conferees also stated their expectation as to how HHS would handle Medicare appeals with the increased workload imposed by the bill:

With the additional workload that would be established under the bill, it is the conferee's expectation that HHS would give serious consideration to establishing a separate office of hearings and appeals for HCFA or otherwise creating a group of hearing officers devoted exclusively or predominately to Medicare appeals.³²⁹

Congress dropped these appeals provisions from COBRA prior to enactment at the request of the Reagan administration.

In its next session, Congress exhibited an interest in Medicare ap-

Containment: Joint Hearing Before the House Select Comm. on Aging and the Task Force on the Rural Elderly, 99th Cong., 1st Sess. (1985); Medicare Beneficiary Appeals Process Technical Appendixes to the ProPAC Report and Recommendations to the Secretary, April 1, 1986, Appendix C, at 162; Government Accounting Office, Information Requirements for Evaluating the Impacts of Medicare Prospective Payment on Post-Hospital Long-Term-Care Services: Preliminary Report (PEMD 85-8 Feb. 21, 1985).

325. See Peterson, *Legislative Changes Urged Regarding Medicare Appeals*, HEALTH L. VIGIL 12 (May 3, 1985). This coalition included representatives of the American Hospital Association, the American Association of Homes for the Aging, the American Association of Retired Persons, the Catholic Health Association, the Federation of American Hospitals, the National Association for Home Care, and the National Senior Citizens Law Center. The Coalition developed recommendations for a variety of reforms.

326. On January 22, 1985, Representative Chappell introduced H.R. 579 to allow administrative review of claims under Part B of the Medicare program of \$50 or more and judicial review of claims of \$1,000 or more. H.R. 579, 99th Cong., 1st Sess. (1985); 131 CONG. REC. H129 (daily ed. Jan. 22, 1985).

327. Social Security Act, § 1862(a)(1)(A), 42 U.S.C. § 1395y(a)(1)(A) (Supp. II 1984).

328. See sources cited *supra* note 25.

329. Proposed H.R. REP. NO. 453, 99th Cong., 1st Sess. (1985) The House never adopted this conference report.

peals issues and enacted significant reforms. One bill would have established a Social Security Court with exclusive jurisdiction over various provisions of the Social Security Act, abolished the Appeals Council, and accorded judicial review in the Social Security Court for any individual who is a party to any final decision of the Secretary or for whom the Secretary has delayed his final decisions longer than 90 days after an ALJ's determination.³³⁰ In the Omnibus Budget Reconciliation Act of 1986, Congress enacted several reforms in the Medicare appeals system, including establishing administrative and judicial review of Part B claims over set amounts.

IV. PROGRAM ADMINISTRATION ISSUES

The Medicare program makes extraordinary and unprecedented use of private organizations to perform important administrative, monitoring, and adjudicative functions, even to the extent that most beneficiaries and providers rarely have direct contact with HCFA regarding Medicare coverage and payment determinations.³³¹ Beneficiaries and providers have raised consistent complaints regarding the administration of the Medicare program by HHS, HCFA and its fiscal intermediaries, carriers, and, more recently, PRO's. There are three major concerns in this regard. The first concern is the way in which HCFA and its fiscal intermediaries and carriers make coverage and payment determinations in individual cases. The second concern is the process that HHS and HCFA have followed in updating the hospital payment rates under the prospective payment system. The third concern is HCFA's implementation of the PRO program almost completely through program instructions rather than informal rulemaking.

330. H.R. 4419, Social Security Procedures Improvement Act of 1986, 99th Cong., 2d Sess. (1986); 132 CONG. REC. H1204 (daily ed. March 17, 1986).

331. The question of whether the delegation of adjudicative authority to fiscal intermediaries and carriers is constitutionally valid has been raised and addressed in several judicial decisions. *Chelsea Community Hosp. v. Michigan Blue Cross Ass'n*, 630 F.2d 1131 (6th Cir. 1980); *St. Louis Univ. v. Blue Cross Hosp. Servs.*, 537 F.2d 283 (8th Cir. 1976), *cert. denied*, 429 U.S. 977 (1976); *St. John's McNamara Hosp. v. Associated Hosp. Servs., Inc.*, 410 F. Supp. 67 (S.D. 1976); *Langhorne Gardens, Inc. v. Weinberger*, 371 F. Supp. 1216 (E.D. Pa. 1974); *Temple Univ. v. Associated Hosp. Servs.*, 361 F. Supp. 263 (E.D. Pa. 1973); *Coral Gables Convalescent Home, Inc. v. Richardson*, 340 F. Supp. 646 (S.D. Fla. 1972). In these cases, the courts have ruled that the delegation was appropriate provided that certain safeguards (e.g., opportunity for fair hearing) were present. See *Homer & Platten, supra* note 196, at 126-29 (discussing unconstitutionality of delegating quasi-judicial powers to intermediaries).

A. *Intermediary and Carrier Coverage and Payment Determinations*

Inherent in the administration of determining coverage of and payment for the health care services reflected in the 366 million claims of 30 million beneficiaries are multiple opportunities for discretionary action by the thousands of employees of fiscal intermediaries, carriers, and PRO's. These decisions are highly technical and individualistic and cannot always be made with reference to a general regulation. There is great pressure on fiscal intermediaries, carriers, and PRO's to make these determinations efficiently and strictly in order to control the administrative costs of the Medicare program.

There are three specific concerns with respect to how fiscal intermediaries and carriers make coverage and payment determinations in individual cases. First, the standards and guidelines for making coverage and payment decisions are contained in health insurance manuals and program instructions, which are not promulgated under section 553 of the Administrative Procedure Act³³² and are not readily accessible to beneficiaries or providers.³³³ Second, fiscal intermediaries, carriers, and now PRO's are bound by restrictive HCFA program directives and are subject to cost containment pressures imposed by their contracts with HCFA. These pressures cause the groups to be extremely strict, and often wrong, in their coverage and payment determinations. Third, the manner in which carriers, fiscal intermediaries, and PRO's advise beneficiaries and providers about coverage and payment determinations is very complex, often unclear, and, in the case of beneficiaries, effectively precludes many beneficiaries from exercising their appeal rights in an informed fashion.

1. *Use of Unpublished Standards and Guidelines*

A major criticism of the coverage determination process is that HCFA has defined criteria for coverage through agency manuals and other program instructions not promulgated as rules under the Administrative Procedure Act. These materials often define coverage of Medicare benefits and can be critical in determining coverage in questionable cases. These manuals are very complex and often inaccessible, as well as incomprehensible, to the average beneficiary or his representa-

332. 5 U.S.C. § 553 (Supp. II 1984).

333. See *supra* notes 25-28 and accompanying text (describing health insurance manuals in existence, but noting they are generally not available to public or providers because of size, cost; and need for update).

tive. Perhaps most disturbing, however, is that fiscal intermediaries and carriers often make coverage and payment decisions according to informal, unwritten policies that are used in the organization's insurance business and are not HCFA program instructions.

This latter problem is exemplified in the recent case of *Fox v. Bowen*.³³⁴ The case involved the practice of a fiscal intermediary that made coverage decisions about physical therapy services for patients in skilled nursing facilities on the basis of a "rule of thumb" not published in regulations, HCFA manuals, or other official Medicare program instructions. Moreover, the decisions were inconsistent with existing regulations and manual provisions pertaining to coverage of physical therapy services.³³⁵ In *Fox v. Bowen*, the United States District Court for Connecticut ruled that intermediaries should determine eligibility for benefits on an individual basis, and that use of "rules of thumb" was contrary to the applicable regulations:

It is contrary to such regulations for an intermediary to deny benefits on the basis of informal presumptions or "rules of thumb," that are applied across the board without regard to the medical condition or therapeutic requirements of the individual patient.³³⁶

2. Restrictive Interpretations of Coverage Rules

The Medicare program encourages fiscal intermediaries and carriers to construe Medicare coverage rules strictly in order to minimize costs to the Medicare program. This has been Medicare's policy since the early 1970's.³³⁷ Specifically, in its health insurance manuals and other program directives, HCFA interprets statutory definitions of benefits more restrictively. An early example of this practice was the strict interpretation of "skilled nursing care" and an expansive interpretation of "custodial care" in order to effectively reduce the use of skilled nurs-

334. [1986-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 35,374 (D. Conn. Apr. 2, 1986) (holding no coverage for non-weightbearing limbs, termination of benefits when patients can walk fifty feet, or no coverage for amputees who are not being fitted for prosthesis).

335. See 42 C.F.R. §§ 409.30-.36 (1986) (stating requirements beneficiaries must meet for coverage of post-hospitalization and skilled nursing facility care); *HHS Skilled Nursing Manual* (HIM-13) § 3101.08 (1986).

336. [1986-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 35,374, at 10,938 (D. Conn. Apr. 23, 1986).

337. See Butler, *supra* note 206; Wilson, *Benefit Cutbacks in the Medicare Program Through Administrative Agency Fiat Without Procedural Protections: Litigation Approaches on Behalf of Beneficiaries*, 16 GONZ. L. REV. 533, 550-53 (1981) (discussing restrictive policies of medicare program).

ing facility benefits by Medicare beneficiaries.³³⁸ HCFA fiscal intermediaries and carriers currently engage in this type of practice throughout the Medicare program.

HCFA and carriers use an especially restrictive formula for calculating the reasonable charge of a physician's fee, resulting in a low level of payment for their services.³³⁹ In Fiscal Year 1984 reasonable charge reductions were made on 83.1% of unassigned claims. The reductions totaled \$2.7 billion, and the amount was paid by beneficiaries, averaging \$29.69 per approved claim.³⁴⁰

Beneficiaries and providers have expressed concern about the restrictive interpretation of coverage rules in view of the fact that these rules are significant interpretations of the Medicare statute. The rules are not promulgated as informal rules under the Administrative Procedure Act, with the requisite notice and comment procedures.³⁴¹ In *Linoz v. Heckler*,³⁴² the Ninth Circuit, finding federal question jurisdiction on the basis of *Bowen v. Michigan Academy of Family Physicians*,³⁴³ invalidated a carrier's manual provision on coverage of ambulance services,³⁴⁴ holding that it was a substantive rule and thus was invalid because not promulgated according to the informal rulemaking procedures of the Administrative Procedure Act.

Certain practices regarding coverage determinations for home health services must be considered. The first is HCFA's "technical denials" policy. Pursuant to this policy, the fiscal intermediary must deny payment for home health visits on grounds that the visit did not meet statutory or regulatory coverage requirements, i.e., where the beneficiary was not "confined to home" or was not "in need of intermittent skilled nursing care."³⁴⁵ Since these denials are not based on medical grounds, they are not subject to the waiver of liability rules. Thus, the home

338. See *supra* notes 206-210 and accompanying text (discussing waiver of liability).

339. See Government Accounting Office, *Reasonable Charge Reductions Under Part B of Medicare* (HRD-81-12, Oct. 22, 1980); Government Accounting Office, *More Action Needed to Reduce Beneficiary Underpayments* (HRD-81-126, Sept. 13, 1981); see also Government Accounting Office, *Medicare Part B Beneficiary Appeals Process* (HRD-85-79 June 28, 1985).

340. Congressional Research Service, *Physician Reimbursement Under Medicare: Background Paper, reprinted in Senate Finance Comm. Hearings on Reform of Medicare Payments to Physicians 2*, 26.

341. See, e.g., *Linoz v. Heckler*, 800 F.2d 871 (9th Cir. 1986). Two other pending cases are considering this issue. *Vorster v. Secretary*, No. 84-9700-ER (C.D. Cal. filed June 26, 1986); *Griffith v. Bowen*, No. 86-2556-Y (D. Mass. 1986).

342. 800 F. 2d 871 (9th Cir. 1986).

343. 106 S. Ct. 2133 (1986).

344. *Carriers Manual* § 2120.3F.

345. 42 C.F.R. § 409.42(b) (1986).

health agency has no right to appeal the determinations. Providers argue that the coverage requirements of being "confined to home" and "in need of skilled nursing care" involve medical determinations and, therefore, should be subject to the waiver of liability rules.³⁴⁶

In the Omnibus Budget Reconciliation Act of 1986, Congress sought to solve the problem posed by technical denials with respect to home health services. Congress provided that beneficiaries could appeal any coverage or payment decision regarding home health services.³⁴⁷ Congress specified further that coverage denials based on a determination that the individual is not confined to home or in need of skilled nursing care would be subject to the waiver of liability rules, and thus providers could effectively appeal these coverage denials.³⁴⁸ Congress also mandated that the Secretary report back to Congress on the frequency and distribution of coverage denials for home health, extended care, and hospice service in 1987 and 1988.³⁴⁹

Another concern of home health agencies is HCFA's recent practice of denying coverage on an essentially statistical basis. By using a sample of claims, HCFA projects the total amount of overpayment that should be assessed for a cost year. HCFA effectively demands repayment for hypothetical claims that are not related to real claims. In a beneficiary appeal before an ALJ,³⁵⁰ HCFA justified this approach on grounds of its "enormous logistical problems in enforcement."³⁵¹ The ALJ rejected HCFA's enforcement justification, ruling the practice of statistical sampling was illegal.³⁵²

346. See *Medicare Appeals Provisions: Hearings on S. 1158 Before the Subcomm. on Health of the Senate Comm. on Finance*, 99th Cong., 1st Sess. 48-49 (1985) (statement of the Catholic Health Association on Medicare Appeals), 129-32 (statement of the National Association for Home Care).

347. Omnibus Budget Reconciliation Act of 1986, § 9313(b) (amending Social Security Act § 1869, 42 U.S.C. § 1395ff (1982)).

348. Omnibus Budget Reconciliation Act of 1986, § 9305(g) (amending Social Security Act, § 1879, 42 U.S.C. § 1395pp (1982)).

349. *Id.*

350. *In re Albuquerque Visiting Nursing Services, Inc.*, No. HIP-000-61-0022 (Office of Hearing and Appeals, Social Security Administration, July 1, 1985).

351. *Id.*

352. In holding the practice illegal, the ALJ stated:

Difficulty in enforcement cannot in any case confer authority for the government to act in contravention of law, or confer authority for the government to take action against individuals or private organizations where no such authority has been granted by Congress. The procedures for processing Medicare Part A claims, the rights of the parties against each other, and the rights to appeal are all clearly delineated in the statutes and the regulations fully promulgated thereunder. Use of a sampling method contravenes those procedures and abrogates those rights. See 42 U.S.C. 1395ff and 1395pp and 42 C.F.R. 701 et seq. Individual review of each case is mandated. The liability of the provider, the individ-

On February 20, 1986, HCFA issued HCFAR-86-1, a ruling specifically authorizing Medicare carriers, fiscal intermediaries, and PRO's to use statistical sampling to project overpayments to providers and suppliers "when claims are voluminous and reflect a pattern of erroneous billing or overutilization and when a case-by-case review is not administratively feasible."³⁵³ HCFA justified this approach on grounds that the federal government has an inherent right to recoup federal funds paid out illegally or erroneously and that this right has been extended to the Medicare program in several appellate court decisions.³⁵⁴ HCFA stated that sampling was necessary because the cost of determining overpayments for the "vast number" of Medicare claims on a case-by-case basis would be "prohibitively high."³⁵⁵ Issuance of this ruling suggests that HCFA plans to continue using sampling techniques to determine overpayments to home health agencies and other providers and suppliers. While the HCFA ruling suggests that this practice will curtail ongoing abuse by providers, it may also inhibit providers from delivering covered services to Medicare beneficiaries.

HCFA also encourages intermediaries and carriers to reduce costs of claims through the contracting process. For example, HCFA has allegedly awarded contracts to companies competing to become fiscal intermediaries for home health agencies on the basis of the company's past performance in denying coverage on Medicare claims.³⁵⁶ Blue Cross and Blue Shield Association of America, on behalf of its members' plans, which comprise the great majority of Medicare intermediaries and carriers, argues that there are no such incentives and pressures to deny or underpay Medicare claims.³⁵⁷ However, Blue Cross does acknowledge that severe budgetary pressures imposed by HCFA contracts have precluded improvements, such as computer system upgrading and better beneficiary education, that would mitigate

ual and HCFA may only be determined by a fact review of each case.

Id.

353. HCFAR-86-1, *Use of Statistical Sampling to Project Overpayment to Medicare Providers and Suppliers* (Feb. 20, 1986).

354. *Id.* (citing *Mount Sinai Hosp. v. Weinberger*, 517 F.2d 329 (5th Cir. 1975); *Wilson Clinic and Hosp., Inc. v. Blue Cross*, 494 F.2d 50 (4th Cir. 1974)). HCFA also pointed out that several courts had recognized sampling as a "valid audit technique" in the Medicaid program. See *Illinois Physicians Union v. Miller*, 675 F.2d 151 (7th Cir. 1982); *Georgia v. Califano*, 446 F. Supp. 404 (N.D. Ga. 1977); *New Jersey Welfare Rights Org. v. Cahil*, 349 F. Supp. 501 (D.N.J. 1972); *Rosado v. Wyman*, 322 F. Supp. 1173 (E.D.N.Y. 1970), *aff'd*, 402 U.S. 911 (1971).

355. HCFAR-86-1, *supra* note 353.

356. See *Medicare Appeals Provisions: Hearings on S. 1158 Before the Subcomm. on Health of the Senate Comm. on Finance*, 99th Cong., 1st Sess. 169-78 (1985) (statement of the American Federation of Home Health Agencies).

357. *Id.* at 294-97 (statement of Blue Cross and Blue Shield Association).

the problem of underpaying or denying large volumes of beneficiary claims.³⁵⁸ There are some home health agencies that have expressed concern that HCFA's contracts with PRO's contain strong incentives for PRO's to stress cost containment rather than quality improvement in their hospital reviews under the prospective payment system.³⁵⁹

Because of severe budgetary pressures, HCFA has exhorted these organizations to tighten up in their coverage determinations and often, as is the case with PRO's, make reductions of utilization of hospital and other services a specific contract goal.³⁶⁰ In Fiscal Year 1987 HHS asked for \$7 million for a "management initiative" that "systematically focuses on home health utilization and the medical necessity of services," anticipating that the medical review and audit activities under this initiative would yield \$989 million in savings in Fiscal Year 1987.³⁶¹ While such initiatives are certainly laudatory as well as essential, one might question whether they contain added incentives for intermediaries and carriers to unfairly curtail beneficiaries' benefits.

3. Information on Coverage Determinations

The third concern with respect to beneficiary coverage determinations is the nature of the information that fiscal intermediaries and carriers give beneficiaries, advising them of the disposition of their claims and the status of their appeals. This has been a particularly controversial issue with respect to Part B because beneficiaries are directly liable for any services that are not covered and for when payment benefits do not cover the provider's full charge.

The nature of the Part B initial notice to Medicare beneficiaries — the Explanation of Medicare Benefits (EOMB) — was litigated in *Gray Panthers v. Heckler*.³⁶² The United States Court of Appeals for the District of Columbia Circuit ruled that the EOMB violated procedural due process because the notice was incomprehensible to an average elderly person. The denial did not state in sufficient detail the specific reason why a claim was denied. Without such information, a beneficiary would be unable to decide whether to appeal and on what basis. As a result of this litigation, HHS and counsel for the Gray

358. *Id.* at 297.

359. *Id.*

360. *See supra* notes 122-25 and accompanying text (discussing PRO's powers).

361. *HHS Fiscal Year 1987 Budget Request*, *supra* note 22.

362. *Gray Panthers v. Califano*, 466 F. Supp. 1317 (D.D.C. 1979), *rev'd and remanded*, 652 F.2d 146 (D.C. Cir. 1980), *reh'g on remand*, [1982 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 32,144 (D.D.C. 1982), *remanded*, 716 F.2d 23 (D.C. Cir. 1983).

Panthers agreed to substantial modifications of the EOMB form.³⁶³ Most of these changes required additional explanation, for either a denial of coverage or a limit on payment for services, that describes the specific reason for the denial to the beneficiary and gives the beneficiary the requisite information to determine whether an error had been made and an appeal is appropriate.³⁶⁴ Other changes include modifications in the appearance and the language of the notice, i.e., discontinuing use of insurance jargon to explain actions on the claim.

Other Medicare program communications to beneficiaries have come under similar attack. In *David v. Heckler*,³⁶⁵ the United States District Court for the Eastern District of New York considered challenges to the information received in the reconsideration procedure before the beneficiary requests a fair hearing on a claim determination.³⁶⁶ The court, concerned about the carrier's reasonable charge reductions and resulting financial liability of beneficiaries, as well as the high rate of reversals on reconsiderations by the particular carrier involved in the case,³⁶⁷ ruled in favor of plaintiff beneficiaries. The court reasoned that plaintiffs had been denied due process because "the notices do not detail reasons for adverse action,"³⁶⁸ and thus beneficiaries were "effectively denied an 'opportunity to meet' the case against them."³⁶⁹ It should be pointed out that the court's criticism of the notice, in the words of a ProPAC report,³⁷⁰ was "scathing":

The fact is that the letters are written at a level well beyond most in this segment of the population, with no discernable added benefit from complexity in information provided. The language used is bureaucratic gobbledegook, jargon, double talk, a form of officialese, federalese and insurancese, and doublespeak. It does

363. *Gray Panthers v. Heckler*, [1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,981 (D.D.C. Nov. 4, 1985).

364. *Id.*

365. 591 F. Supp. 1033 (E.D.N.Y. 1984).

366. The court did not rule on the adequacy of the EOMB because this issue was before the United States District Court for the District of Columbia in *Gray Panthers v. Schweiker*, a nationwide class action suit. *Id.* at 1036.

367. The court commented on evidence that this carrier's reversal rate was often as high as 70%, as well as the fact that only 3% of beneficiaries sought review of claims and only .04% requested a fair hearing. *Id.* at 1044.

368. *Id.* at 1043 (citing *Goldberg v. Kelly*, 397 U.S. 254 (1970)). In *Goldberg* the Court found that merely providing a welfare recipient the opportunity to submit a written statement of his position was insufficient. *Id.* at 268-69 (Frankfurter, J., concurring).

369. *Id.* at 1043 (quoting *Joint Anti-Fascist Refugee Comm. v. McGrath*, 341 U.S. 123, 171-72 (1951) (Frankfurter, J., concurring)).

370. See *Technical Appendixes to the ProPAC Report and Recommendations to the Secretary, April 1, 1986*, Appendix C, at 174 (discussing Medicare beneficiary appeals process).

not qualify as English.³⁷¹

The problem with how HCFA provides beneficiaries with information about their benefits and determinations for coverage and payment is intractable and one to which HCFA is not insensitive. HCFA has published a booklet generally describing the Medicare program for beneficiaries³⁷² and, in July 1984, published a pamphlet outlining appeal rights of beneficiaries regarding hospital insurance claims.³⁷³ Concerns remain, however, that HCFA's communications with beneficiaries on a variety of matters is inadequate. In its Fiscal Year 1986 recommendations to the Secretary, ProPAC made a recommendation specifically requesting the Secretary to provide more and better information about the payment system to both beneficiaries and providers.³⁷⁴

In responding to this recommendation, HCFA reported that it had worked with beneficiary groups on forms for certain types of information and was preparing another pamphlet on beneficiary appeal rights.³⁷⁵ Nevertheless, the problem of comprehensible communication to beneficiaries remains a critical issue for the Medicare program.

In the Omnibus Budget Reconciliation Act of 1986, Congress specifically required that, upon admission, hospitals provide beneficiaries with a written statement (to be prepared by the Secretary by April 1987) of the beneficiary's rights to Medicare hospital and post-hospital benefits, the beneficiary's appeal rights, and liability for any charges, including those resulting from an unsuccessful appeal.³⁷⁶ In addition, Congress required hospitals to provide more discharge planning service for Medicare beneficiaries.³⁷⁷

371. 591 F. Supp. at 1043.

372. See HEALTH CARE FINANCING ADMINISTRATION, PUB. NO. HCFA-10050, YOUR MEDICARE HANDBOOK (1986) (describing whether certain services are covered by Medicare and how Medicare payment will be made).

373. HEALTH CARE FINANCING ADMINISTRATION, PUB. NO. HCFA-10085, YOUR RIGHT TO APPEAL DECISIONS ON HOSPITAL INSURANCE CLAIMS (1984).

374. *ProPAC Report and Recommendations to the Secretary, April 1, 1986*, at 7 (Recommendation 15: Beneficiary and Provider Information). For an excellent pamphlet on beneficiary rights under the prospective payment system, see American Association of Retired Persons, *Medicare's Prospective Payment System - Knowing Your Rights* (1985) (describing prospective payment system from consumers' perspective).

375. See 51 Fed. Reg. 19,970, 19,998 (1986) (to be codified at 47 C.F.R. pts. 405, 4120) (discussing HCFA's intention to develop new pamphlet on beneficiary appeal rights).

376. Omnibus Budget Reconciliation Act of 1986, § 9305(b) (amending Social Security Act, § 1866(a)(1), 42 U.S.C. § 1395cc(a)(1) (1982)).

377. Omnibus Budget Reconciliation Act of 1986, § 9305(c) (amending Social Security Act, § 1861(e)(6), 42 U.S.C. § 1395x(e)(6) (1982)).

B. Setting the Price Under the Prospective Payment System

Each year HHS is required to publish an informal rule updating the hospital payment rates for the next fiscal year.³⁷⁸ In updating hospital payment rates under the prospective payment system, HHS is required to consider and comment on ProPAC's recommendations on the proposed rule updating the DRG payment rates.³⁷⁹ Hospitals have charged that while HHS follows the requisite rulemaking procedures in form, it does not indicate in the rule how the payment rates are actually derived.³⁸⁰ Specifically, the hospital industry has claimed that HCFA has no analytical basis for the factors it selects to update the payment rates and that its predominant goal is to reduce Medicare expenditures for hospital services, rather than to set a fair price.³⁸¹

378. See *supra* notes 150-53 and accompanying text (discussing procedure for updating payment rules under Social Security Act).

379. See *supra* notes 133-53 and accompanying text (discussing creation and duties of ProPAC).

380. Letter from Jack Owen, Executive Vice President of the American Hospital Association, to William Roper, M.D. Administrator of the Health Care Financing Administration (July 3, 1986) (comments on Proposed PPS Rules for FY 1987). HHS does respond to ProPAC's recommendations. This does not, however, make public the calculations for payment rates.

381. *Id.* at Attachment A. In its comments to the regulations updating the DRG prices for FY 1987, the American Hospital Association stated:

In response to the FFY 1986 [sic] proposed rule on PPS, AHA commented that "the Health Care Financing Administration (HCFA) has an obligation to the public to do more in the Notice than provide a statement of those beliefs that form the basis for the rule; HCFA must provide evidence which validates their beliefs." For a second year, the notice of proposed rates fails to document the appropriateness and validity of the update factor and other changes. Absent detailed evidence, AHA must assume that the primary motivating factor in the development of each component of the rate calculation is budget reduction. We can only conclude that HCFA is not truly interested in the adequacy of the rates that are promulgated, the equity of payments to hospitals or the administration of the Medicare program in a manner that reflects its responsibilities to Medicare beneficiaries and providers. If these issues had been considered in the development of the PPS rates for FY 1987, the update factor and other modifications identified by HCFA would be better documented by quantitative and qualitative evidence of the adjustments and their appropriate levels.

Id.

The actions of HHS in its handling of the statutory directive, which provides that HCFA create an adjustment to reflect the higher costs of hospitals serving a disproportionate share of Medicare and low income patients, gives some support to the concerns about HHS' motive in setting the rates under the prospective payment system. See Social Security Act, § 1886(d)(C)(i), 42 U.S.C. § 1395ww(d)(5)(C)(i) (1982 & Supp. III 1985) (codifying Social Security Act of 1983 concerning hospital's specific rate based on hospital's actual operating costs). HCFA has consistently maintained that hospitals with a high volume of Medicare and low income patients do not experience justifiably higher Medicare costs and thus a special adjustment in the rate is not warranted for these hospitals. 48 Fed. Reg. 39,752, 39,783 (1983) (Preamble to Proposed Rule). HHS refused to develop such an adjustment despite ProPAC recommendations

HHS has not, for the most part, adopted the recommendations of ProPAC concerning the methodology used for updating the hospital payment rate. HHS almost always uses a methodology that results in a lower payment rate. Its refusal to follow ProPAC's recommendations to update payment rates and recalibrate DRG's in a manner that results in lower payments has led some in the hospital industry to question ProPAC's effectiveness in influencing the Medicare hospital rate-setting process.³⁸²

ProPAC asserted that its approach and HHS's approach in updating the Medicare prospective payment system for Fiscal Year 1987 are "diverging in significant ways" and that this divergence appears to be based on a "difference in philosophy between the Commission and the Department."³⁸³ Central to ProPAC's philosophy is the belief that the

to do so in its 1985 and 1986 reports to the Secretary. *ProPAC Report and Recommendations to the Secretary, April 1, 1985*, at 37; see, e.g., *Redbud Hosp. Dist. v. Heckler*, [1984-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,085 (C.D. Cal. Jul. 30, 1984), *application for stay of preliminary injunction granted*, 106 S. Ct. 1 (1985) (J. Rehnquist sitting as Circuit Judge); *Samaritan Health Center v. Heckler*, [1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,862 (D.D.C. Aug. 28, 1985). In *Samaritan Health Center*, the court ruled that HHS had discretion to implement the allowance for disproportionate share hospitals, but suggested that HHS may have abused its discretion in this instance. In the Deficit Reduction Act of 1984, Congress mandated HHS to establish an allowance and publish a definition of disproportionate share hospitals by December 31, 1985. Deficit Reduction Act of 1984, § 2315 (h)(1), 42 U.S.C. § 1395ww(h)(1) (Supp. III 1985). HCFA developed the requisite definition, but only 108 hospitals in the nation qualified, and no adjustment was allowed even for those hospitals. 50 Fed. Reg. 53,398, 53,399 (1985).

Questions have been raised whether HHS has really cooperated with the statutory mandate with respect to this issue, given that Congress had originally contemplated that this allowance would be available to large, urban public or voluntary hospitals as well as poor rural hospitals serving large proportions of aged and poor. The hospitals selected by HCFA were not of this character. *Id.* See generally H.R. REP. NO. 25, 98th Cong., 1st Sess. 132-59 (1983); H.R. REP. NO. 47, 98th Cong., 1st Sess. 90-114, 189-205 (1983). Congress finally rejected HHS's disposition of this issue in COBRA, where it provided that disproportionate share hospitals, defined according to the proportion of revenue from the Medicare and Medicaid programs, will receive additional payments under the prospective payment system. Consolidated Omnibus Budget Reconciliation Act of 1986, § 9105 (amending Social Security Act, § 1886(d)(5), 42 U.S.C. § 1395(d)(5) (Supp. III 1985)). In the Omnibus Budget Reconciliation Act of 1986, Congress further refined the methodology for paying disproportionate share hospitals to provide additional assistance to those in rural areas. Omnibus Budget Reconciliation Act of 1986, § 9306 (amending Social Security Act, § 1886(d)(5)(F), 42 U.S.C. § 1395ww(d)(5)(F) (1982)).

382. See Firshein, *ProPAC Weakened by Concern Over Federal Deficit*, Hospitals, Apr. 5, 1986, at 24.

383. Letter from Stuart H. Altman, Ph.D., Chairman of the Prospective Payment Assessment Commission, to William L. Roper, M.D., Administrator of the Health Care Financing Administration (July 2, 1986) (comments of the Prospective Payment Assessment Commission on the Notice of Proposed Rulemaking of June 3, 1986, concerning Fiscal Year 1987 changes in inpatient hospital prospective payment system).

prospective payment system "should be a flexible and evolutionary system responsive to changing health technology and practice patterns and to the distributional impacts of payments within the system," and further that adjustments in the system are "critical to maintaining an environment which fosters innovation and scientific advancement."³⁸⁴ HHS, in relying on averaging methodologies and ignoring adjustments in the payment system to reflect special circumstances, does not advance ProPAC's philosophy.³⁸⁵

Congress has overridden HHS's recommendations concerning the updating factors for hospital payment rates in Fiscal Year 1986. There is some indication that it might do so again for Fiscal Year 1987 and Fiscal Year 1988. The House Budget Committee has publicly stated its disapproval of HHS's performance on implementing the legislation concerning development of update factors.³⁸⁶

In the Omnibus Budget Reconciliation Act of 1986, Congress overrode HHS's update factors for the Fiscal Year 1987 payment rates. It also established greater congressional involvement in the hospital rate-setting process. HHS's unresponsiveness to ProPAC recommendations and its failure to explain the basis of how it updates the prospective payment rates is quite serious, particularly because hospitals are expressly precluded from challenging the DRG's or the methodology for their recalibration through administrative or judicial review.³⁸⁷ Congress intended for ProPAC to serve as a check to HHS in setting and recalibrating DRG payment rates. ProPAC was meant to protect the hospitals' legitimate interest in a fair payment rate. Congress has based its legislative action on a sophisticated analysis of hospital payment rates provided by ProPAC, instead of adopting HHS's recommendations on updating hospital payment rates.

C. Implementation of the PRO Program

Another, but quite different, problem is the manner in which HCFA has implemented the PRO program. This major new program was authorized by the Peer Review Improvement Act of 1982.³⁸⁸ Congress had required all hospitals to have contracts with PRO's by October 1984. This would ensure that the requisite medical reviews necessary

384. *Id.*

385. *Id.*

386. H.R. REP. NO. 727, 99th Cong., 2d Sess. 427 (1986).

387. See *infra* notes 496-502 and accompanying text (discussing HHS and congressional concern over judicial review of prospective payment system).

388. See *supra* notes 118-32 and accompanying text (discussing creation and implementation of PRO's and their characteristics).

for monitoring the prospective payment system were conducted. Although the President signed the Peer Review Improvement Act in September 1982, HCFA did not publish notice of a request for proposals for the contracts from organizations seeking to become PRO's until August 29, 1983.³⁸⁹ It also did not promulgate final regulations for the program until April 1985.³⁹⁰ HCFA has relied almost exclusively on program directives and provisions of the PRO contracts to implement the PRO program.³⁹¹ PRO regulations do not address all implementation procedures and issues.³⁹² The hospital industry has been quite concerned about the procedures HCFA has followed for the implementation of the PRO program since the inception of the program in 1982. This is especially true when HCFA began the contracting process without having promulgated any regulations to implement the program. In October 1984 the American Hospital Association filed a petition for rulemaking with HCFA under section 553(e) of the Administrative Procedure Act.³⁹³ When the Secretary did not act on the petition, the American Hospital Association brought suit in the United States District Court for the District of Columbia. The Association alleged that HCFA had violated certain procedural and substantive rights of hospitals by implementing provisions of the PRO program without adhering to rulemaking procedures and by refusing the petition for rulemaking.³⁹⁴

The district court ruled that most of the program directives through which HCFA had implemented the PRO program were actually substantive rules, and thus were invalid because the rules were not promulgated pursuant to the informal rulemaking procedures of the Adminis-

389. 48 Fed. Reg. 39,160 (1983) (soliciting comments on scope of work prepared as part of Request For Proposal (RFP) for utilization and quality control program beginning third quarter of fiscal year 1984, but not constituting a RFP itself). The final RFP was not issued until February 29, 1984. No final version of the scope of work of the RFP was published in the *Federal Register*.

390. 50 Fed. Reg. 15,312-15,374 (1986) (codified in scattered sections of Title 42 C.F.R.).

391. See PRO Manual IM 85-2 (replacing PSRO Transmittal No. 107); PRO Manual IM 85-3 (replacing PSRO Transmittal No. 108); see also Medicare Hospital Transmittal No. 367, § 287.4a; Medicare Intermediary Manual Transmittal No. 1079, § 3789c, & No. 1102; PRO Directive No. 2; Health Care Financing Administration, Request for Proposals for PRO Contracts (RFP No. HCFA-84-015 Feb. 29, 1984).

392. See 42 C.F.R. §§ 412.42, 412.44, 412.48, 412.50, 412.52 (1986) (codifying requirements hospitals must meet to receive payments under prospective payment system for inpatient hospital services furnished to Medicare beneficiaries).

393. Petition before the Department of Health and Human Services by the American Hospital Association for Promulgation of Regulations Implementing the Peer Review Improvement Act of 1982 (Oct. 10, 1984).

394. *American Hosp. Ass'n v. Bowen*, 640 F. Supp. 453 (D.C. Cir. 1987).

trative Procedure Act.³⁹⁵ The court also ruled that HCFA's denial of the American Hospital Association's petition for rulemaking was arbitrary and capricious. This decision wrought considerable confusion in the PRO program. It jeopardizes the PRO's important function of monitoring hospital performance in delivering high quality services to Medicare beneficiaries in a cost-effective manner.³⁹⁶ Apart from this decision, Congress also has exhibited considerable dissatisfaction with the implementation of the PRO program generally and has made several substantive changes in past legislation.³⁹⁷

V. ADMINISTRATIVE HEARING ISSUES

This chapter discusses concerns about administrative hearing procedures for disputes over coverage and payment determinations under the Medicare program. These problems are diverse, but all involve the issue of whether the various hearing processes in the Medicare appeals system protect the rights of beneficiaries and providers to procedural due process of law. The Supreme Court has interpreted the Due Process Clause of the fifth amendment to require that government action that affects the entitlement interest of beneficiaries in a federal program must follow appropriate procedures, ensuring that the beneficiary is properly notified of the proposed government action and has an opportunity to contest the action in a meaningful fashion.³⁹⁸ The Supreme Court has established that beneficiaries clearly have an entitlement interest in the Medicare program that is protected under the Due Process Clause.³⁹⁹

395. *Id.*

396. On July 18, 1986, the district court denied the Secretary's motion for reconsideration. However, on September 29, 1986, the court granted the Secretary's motion for stay of the May 30 order pending appeal. Duffy, *Pro-Court Grants Secretary's Motion for Stay*, HEALTH L. VIGIL 5 (Oct. 10, 1986). On October 30, 1986, the Court of Appeals for the District of Columbia Circuit denied a joint motion by the American Hospital Association and HHS for expedited appeal. The court, on its own motion, ordered HHS to show cause why the stay of May 30 order should not be lifted. McCann, *Court Orders HHS to Show Cause in AHA PRO Suit*, HEALTH L. VIGIL 5 (Nov. 21, 1986).

397. See *supra* notes 130-32 and accompanying text (discussing congressional action taken in response to dissatisfaction with PRO program).

398. See, e.g., *Mathews v. Eldridge*, 424 U.S. 319 (1976); *Goldberg v. Kelly*, 397 U.S. 254 (1970). See generally *Friendly, Some Kind of Hearing*, 123 U. PA. L. REV. 1267 (1975).

399. *Accord Gray Panthers v. Schweiker*, 652 F.2d 146 (D.C. Cir. 1980); see also *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773 (1980). This case also established that providers do not have a comparable entitlement interest in the Medicare program. See *St. Francis Hosp. Center v. Heckler*, 714 F.2d 872 (7th Cir. 1983), *cert denied*, 465 U.S. 1022 (1984); *Geriatrics, Inc. v. Harris*, 640 F.2d 262 (10th Cir. 1981), *cert denied*, 454 U.S. 832 (1981).

A. Beneficiary Appeals Under Part A

Since the inception of the Medicare program, beneficiaries have brought numerous appeals, most of which have involved coverage determinations based on medical criteria. A few cases have challenged whether certain services or procedures are covered benefits under Part A or Part B of the Medicare program.⁴⁰⁰ Most beneficiary appeals, however, have involved questions of whether specific services are covered benefits according to medical criteria or whether services are medically necessary or constitute custodial care.⁴⁰¹

Beneficiaries have voiced complaints about administrative review by administrative law judges (ALJ's) and the Appeals Council of the Social Security Administration (SSA). There have been suggestions that the administrative Medicare appeals system, as well as the appeals system for all appeals arising under the Social Security Act, should be restructured.⁴⁰² However, since many of the complaints of Medicare beneficiaries are similar to those of beneficiaries of other Social Security programs and since the American Bar Association, with input from the Administrative Conference of the United States, developed recommendations for modifications of these procedures in another context,⁴⁰³

400. *Heckler v. Ringer*, 466 U.S. 602 (1984); *Lincoz v. Heckler*, 800 F.2d 871 (9th Cir. 1986); *Mayburg v. Heckler*, 740 F.2d 100 (1st Cir. 1984).

401. *See, e.g.*, *Hultzman v. Weinberger*, 495 F.2d 1276 (3d Cir. 1974); *Weir v. Richardson*, 343 F. Supp. 353 (S.D. Iowa 1972); *Reading v. Richardson*, 339 F. Supp. 295 (E.D. Mo. 1972); *Johnson v. Richardson*, 336 F. Supp. 390 (E.D. Pa. 1971); *Sowell v. Richardson*, 319 F. Supp. 689 (D.S.C. 1970); *see also* *Butler, Advocate's Guide, supra* note 206, at 842.

402. *See supra* note 1 and accompanying text (discussing congressional concern over Medicare appeals system).

403. *See* Case Western Reserve School of Law, *ABA-ACUS Symposium on Federal Disability Programs: Report and Recommendations* (Oct. 11, 1985). The conduct of the Appeals Council in the SSA's Office of Hearings and Appeals is of special concern to Medicare beneficiaries, as well as other Social Security program beneficiaries. Under HHS regulations, the SSA Appeals Council is authorized to reopen cases after their disposition by the ALJ. The Appeals Council reopened cases despite another regulatory provision specifically governing when the Appeals Council may initiate review, i.e., any time within 60 days of the hearing decision or dismissal. 20 C.F.R. § 404.969 (1986). This has caused considerable unpredictability in the beneficiary appeals system since the Appeals Council has often initiated review several months after an ALJ decision.

Medicare and Social Security beneficiaries challenged this practice on numerous occasions, and several federal district court decisions ruled that the Appeals Council practice is contrary to the regulations, in spite of the deference customarily given the Secretary in interpreting his own regulations. *See, e.g.*, *Munsinger v. Schweiker*, 709 F.2d 1212 (8th Cir. 1983); *McCuin v. Bowen*, [1986-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 35,443 (D.N.H. Apr. 23, 1986); *Dion v. Secretary of Health and Human Services*, No. 83-442-D (D.N.H. Apr. 25, 1985); *Silvis v. Heckler*, 578 F. Supp. 1401 (W.D. Pa. 1984) (concluding that Appeals Council's right to reopen cases is governed by 20 C.F.R. § 404.969 (1986), which authorizes reopening within 60 days

they will not be addressed in this report. Nevertheless, there are currently some reported problems with beneficiary appeals under Part A that warrant attention: (1) problems with beneficiary appeals of hospital benefits under the prospective payment system; (2) problems with PRO appeal procedures; and (3) deficiencies in appeal procedures for claims under \$100.

1. *Beneficiary Appeals Under the Prospective Payment System*

As might be expected with the implementation of any major nationwide program affecting millions of people and thousands of institutions, there have been unanticipated ramifications. In the case of the prospective payment system, however, these problems have been remarkably few in number given the size and complexity of this program.

Informing Beneficiaries About Appeal Rights. Soon after the implementation of the prospective payment system, reports surfaced that hospitals were discharging Medicare patients early and inappropriately, i.e., "sicker and quicker," and often against their will. The explanation for the premature releases was that the beneficiary's covered Medicare days had "run out."⁴⁰⁴ Further, reports indicated that beneficiaries often did not appeal such decisions because they were unaware of their right to appeal. The decisions appeared to be those of hospital management or attending physicians. Beneficiaries were concerned that they would be liable for the continued stay once they had been notified that continued hospitalization was no longer necessary.⁴⁰⁵

of ALJ's decision, and that regulations authorizing reopening thereafter apply only to beneficiaries' requests to reopen). One circuit court of appeals decision, *Munsinger v. Schweiker*, 709 F.2d 1212 (8th Cir. 1983), has upheld the Appeals Council's interpretation of this regulation.

404. Prospective Payment Assessment Commission, *Beneficiary and Professional Perceptions of PPS Quality of Care, Technical Appendices to the ProPAC Report and Recommendations to the Secretary of Health and Human Services*, Appendix C, at 149-50 (April, 1986); Government Accounting Office, *Information Requirements for Evaluating the Impacts of Medicare Prospective Payment on Post-Hospital Long-Term-Care Services: Preliminary Report* (PEMD-85-8 Feb. 21, 1985).

405. Social Security Act, § 1879, 42 U.S.C. § 1395pp (Supp. II 1984); 42 C.F.R. §§ 405.330-332 (1986). This is not really a new problem, but hospitals have always been able to make implicit decisions about the Medicare coverage of continued hospitalization through the utilization review process without input from the affected patient and with an after-the-fact appeal to the PSRO to challenge the decision that continued stay was no longer necessary. The major difference under the prospective payment system is that now hospitals have a very strong financial incentive to make these implicit coverage decisions. See Price, Katz & Provence, *An Advocate's Guide to Utilization Review*, 9 CLEARINGHOUSE REV. 307 (1977); Neeley-Kvarme, *Administrative and Judicial Review of Medicare Issues: A Guide Through the Maze*, 57 NOTRE DAME L. REV. 1, 9-16 (1981).

Congress and HCFA took immediate steps to address this problem. HCFA developed a notice for hospitals to give all Medicare patients upon admission that would clearly explain the patient's appeal rights with respect to any decision by the hospital, the patient's physician, or the PRO concerning the patient's continued stay.⁴⁰⁶ Further, in its 1986 recommendations to the Secretary, ProPAC urged the Secretary to require hospitals to give beneficiaries immediate notice of appeal rights upon admission. ProPAC also improved the information available to beneficiaries regarding appeals and their rights under the prospective payment system.⁴⁰⁷ ProPAC conducted a brief study which suggested, however, that this was not a widespread problem.⁴⁰⁸ Despite this reassuring ProPAC study, convincing evidence reported in surveys conducted by the American Society of Internal Medicine⁴⁰⁹ and the American Medical Association⁴¹⁰ indicate that premature discharge of Medicare patients is widespread and that the quality of hospital care provided to Medicare patients is declining.⁴¹¹

Congress continues to be concerned about this issue. In the Omnibus Budget Reconciliation Act of 1986, Congress accorded beneficiaries a statutory right to appeal a hospital discharge notice to a PRO while assuring that the beneficiary would not be financially liable for the hospital days incurred between the filing of the appeal and its disposition.⁴¹² As a further check on hospital discharge policies, Congress re-

406. 51 Fed. Reg. 19,970, 19,998 (1986).

407. Prospective Payment Assessment Commission, *Beneficiary and Professional Perceptions of PPS Quality of Care, Technical Appendixes to the ProPAC Report and Recommendations to the Secretary, U.S. Department of Health and Human Service*, Appendix C, at 162 (Apr. 1, 1986). HCFA agreed with ProPAC about the need to address beneficiaries' concerns about receiving better information on the prospective payment system and, specifically, about appeal rights. 51 Fed. Reg. 19,970, 19,998 (1986). HCFA noted that it had released a notice for Medicare beneficiaries, to be given to them upon admission to the hospital, that would explain more specifically beneficiaries' rights to appeal and reconsideration. *Id.* HCFA also stated that it was publishing a pamphlet on beneficiary appeal rights. *Id.*

408. Prospective Payment Assessment Commission, *Beneficiary and Professional Perception of PPS Quality of Care, Technical Appendixes to the ProPAC and Recommendations to the Secretary, U.S. Department of Health and Human Services*, Appendix C, at 147 (Apr. 1, 1986).

409. American Society of Internal Medicine, *The Impact of DRG's on Patient Care: A Survey by the American Society of Internal Medicine March 1984-October 1985*.

410. American Medical Association, *Report of the American Medical Association Board of Trustees: AMA's DRG Monitoring Project and the Prospective Payment System* (Dec. 1985).

411. See also *Senate Special Comm. on Aging, Hearings on Quality of Care under Medicare's Prospective Payment System*, at 1-2.

412. Omnibus Budget Reconciliation Act of 1986, § 9351 (amending Social Security Act, § 1154, 42 U.S.C. § 1330c-3 (1982)).

quired PRO's to review any cases in which a hospital sought to discharge a patient against the recommendation of the attending physician.⁴¹³

2. PRO Appeal Procedures

PRO's have the major responsibility for handling the first stage of a beneficiary's appeal of PRO coverage determinations under the prospective payment system. HCFA has not published standards for PRO reconsideration procedures. There are reports that many PRO's have refused to implement any standards and that they fail to fully understand their adjudicative responsibilities.⁴¹⁴ HCFA has no specific information to date on the volume of PRO appeals for either hospitals or beneficiaries.⁴¹⁵ There is concern about the ability of PRO's to handle these appeals in a fair and expeditious manner.⁴¹⁶ This is an especially troubling situation for hospitals because reconsideration decisions in provider appeals are not subject to administrative or judicial review.⁴¹⁷

3. Deficiencies in Appeal Procedures for Claims Under \$100

As noted above, there is no administrative or judicial review of claims under \$100. Beneficiaries have alleged that the intermediary hearing procedures for Part A and Part B claims under \$100 are inadequate and violate their rights to procedural due process.⁴¹⁸

In reviewing the district court's action, the court of appeals in *Gray Panthers II*⁴¹⁹ ruled that the "adoption of procedures allowing for oral hearings is not warranted" if the total number of cases requiring an

413. *Id.*

414. *Medicare Appeals Provisions: Hearings on S. 1158 Before the Subcomm. on Health of the Senate Comm. on Finance*, 99th Cong., 1st Sess. 151 (1985) (statement of the American Hospital Association); see also Wilson, *How to Appeal Medicare Hospital Coverage Denials under the DRG System*, 20 CLEARINGHOUSE REV. 434 (1986).

415. Letter from Joseph J. Hladky, Director, Office of Medical Review, Health Standard and Quality Bureau, Health Care Financing Administration, to Eleanor D. Kinney, Assistant Professor of Law, Indiana University (Oct. 6, 1986).

416. See Wilson, *supra* note 414.

417. See *infra* notes 506-08 and accompanying text (discussing PRO adjudicative responsibility and preclusion of hospital from receiving judicial review of PRO determinations).

418. See *infra* notes 464-69 and accompanying text (discussing *Gray Panthers* case). The United States Court of Appeals for the District of Columbia Circuit agreed, ruling that more than a "paper" hearing on small Part A claims was required but also ruling an oral hearing is necessary only in the few cases where factual issues involving the credibility or veracity of the claimant are at stake.

419. 716 F.2d 23 (D.C. Cir. 1983).

oral hearing is small.⁴²⁰ Taking this cue, along with testimony of HCFA officials that there are annually only about 100 Part A reconsideration claims under \$100, the district court on remand ruled that oral hearings were not required for small claims under Part A.⁴²¹ Concluding, further, that the Part A notices of coverage determination were "not perfect, but more than adequate," the court ordered no changes in these notices.⁴²²

B. Provider Payment Disputes Under Part A

Since the inception of the Medicare program, providers have often appealed intermediary payment determinations. Early in the program, skilled nursing facilities brought a large volume of appeals. As HHS imposed stricter interpretations of the skilled nursing benefit, Medicare utilization of skilled nursing facilities dropped and the appeals tapered off.⁴²³ Hospital challenges to Medicare payment policies have been extensive since the 1970's, particularly with the advent of orchestrated group appeals by state hospital associations and the American Hospital Association.⁴²⁴ These challenges have chiefly concerned specific methodologies HCFA has used to calculate cost reimbursement. The two outstanding cost reimbursement policies of current interest are (1) how to account for labor and delivery room patient days in determining Medicare reimbursement;⁴²⁵ and (2) HCFA's methodology for calcu-

420. *Id.* at 36.

421. [1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 35,140 (D.D.C. Feb. 14, 1986).

422. *Id.*

423. See *supra* notes 206-09 and accompanying text (discussing 1968 HHS interpretation of "skilled nursing services").

424. See *Special Issue, Medicare Reimbursement Is Examined by AHA's Group Appeals*, HEALTH L. VIGIL (Feb. 4, 1983).

425. HCFA requires that patients in the labor and delivery room area be included in the inpatient census for purposes of determining the number of Medicare patient days, but excludes the costs of labor and delivery room services from the total costs Medicare recognizes for reimbursement purposes. 42 C.F.R. § 405.452(b) (1986); PROVIDER REIMBURSEMENT MANUAL (HIM-15) § 2345. Hospitals claim that this policy understates the number of Medicare patient days and results in lower Medicare reimbursement. Several courts have agreed with hospital challenges to this policy. See *Sioux Valley Hosp. v. Bowen*, 742 F.2d 715 (8th Cir. 1986); *Community Hosp. of Roanoke Valley v. HHS*, 770 F.2d 1257 (4th Cir. 1985); *Central DuPage Hosp. v. Heckler*, 761 F.2d 354 (7th Cir. 1985); *St. Mary of Nazareth Hosp. Center v. Heckler*, 760 F.2d 1311 (D.C. Cir. 1985), *aff'g*, 587 F. Supp. 937 (D.D.C. 1984), *after remand in*, 718 F.2d 459 (D.C. Cir. 1983); *Mt. Zion Hosp. and Medical Center v. Heckler*, 758 F.2d 1346 (9th Cir. 1985); *Beth Israel Hosp. v. Heckler*, 734 F.2d 90 (1st Cir. 1984); *Baylor Univ. Medical Center v. Heckler*, 730 F.2d 391 (5th Cir. 1984); see also *McKeesport Hosp. v. Heckler*, 643 F. Supp. 275 (W.D. Pa. 1986), *appeal pending*, No. 86-3699 (3d Cir. 1987).

lating Medicare's portion of the cost of a hospital's malpractice insurance.⁴²⁶

The implementation of the cost per case and target rate of increase limits under the Tax Equity and Fiscal Responsibility Act, and then the prospective payment system, have generated more litigation. The substantive issues for these hospital appeals fall into three categories: (1) challenges to HCFA's calculation of the hospital's base year costs used to calculate the hospital-specific portion of the standardized amount during the transition period;⁴²⁷ (2) challenges to specific factors, which are used to calculate the federal portion of the standardized amount, that pertain directly to hospitals;⁴²⁸ and (3) exemptions and adjustments for hospitals with special needs and characteristics.⁴²⁹

There are currently four important issues regarding provider appeals: (1) what constitutes a final intermediary decision for purposes of triggering PRRB jurisdiction to hear hospital appeals under the prospective payment system; (2) whether HCFA can correct an error in the

426. Prior to 1979, Medicare treated a hospital's medical malpractice insurance costs like most other costs and reimbursed the hospital according to the proportionate share of Medicare utilization. In 1979, HCFA adopted another method for calculating Medicare's portion of malpractice insurance costs, and this resulted in marked reductions in reimbursement for this cost item. 42 C.F.R. § 405.452(b)(1)(ii) (1986). Several courts of appeal have invalidated this rule. *See, e.g.,* Cumberland Medical Center v. Secretary of HHS, 781 F.2d 536 (6th Cir. 1986); DeSoto General Hosp. v. Heckler, 766 F.2d 182, *as amended by*, 776 F.2d 115 (5th Cir. 1985); Bedford County Memorial Hosp. v. Heckler, 769 F.2d 1017 (4th Cir. 1985); Menorah Medical Center v. Heckler, 768 F.2d 292 (8th Cir. 1985); Lloyd Noland Hosp. and Clinic v. Heckler, 762 F.2d 1561 (11th Cir. 1985); St. James Hosp. v. Heckler, 760 F.2d 1460 (7th Cir. 1985), *cert. denied*, 106 S. Ct. 229 (1985); Humana of Aurora, Inc. v. Heckler, 753 F.2d 1579 (10th Cir. 1985), *cert. denied*, 106 S. Ct. 180 (1985); Abington Memorial Hosp. v. Heckler, 750 F.2d 242 (3d Cir. 1984), *cert. denied*, 106 S. Ct. 180 (1985); *see also* Walter O. Boswell Memorial Hosp. v. Heckler, 749 F.2d 788 (D.C. Cir. 1984), *on remand*, 628 F. Supp. 1211 (D. Colo. 1985). *But see* Charter Medical Corp. v. Bowen, 788 F.2d 728 (11th Cir. 1986), *rev'g on jurisdictional grounds*, 604 F. Supp. 638 (M.D. Ga. 1985) (finding for provider). On April 1, 1986, the Secretary issued an interim final rule that modifies its procedures for calculating malpractice insurance costs but still treats these costs differently than other costs for Medicare reimbursement purposes. 51 Fed. Reg. 11,142 (1986). *See, e.g.,* St. Paul Hosp. v. Bowen, 644 F. Supp. 99 (N.D. Tex. 1986); St. Louis Univ. Medical Center v. Bowen, [1986-2 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 35,506 (E.D. Mo. July 2, 1986) (considering application of revised malpractice regulations); Miami General Hosp. v. Bowen, [1987-1 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 35,865 (S.D. Fla. Sept. 16, 1986) (considering application of revised malpractice regulations).

427. *See infra* notes 430-36 and accompanying text (discussing jurisdiction of PRRB for hospital appeals under prospective payment system).

428. *See* Good Samaritan Medical Center v. Heckler, 605 F. Supp. 19 (S.D. Ohio 1984) (discussing methodology for classifying urban and rural hospitals).

429. *See* Community Hosp. of Indianapolis, Inc. v. Schweiker, 717 F.2d 372 (7th Cir. 1983); Redbud Hosp. Dist. v. Heckler, [1984-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,085 (N.D. Cal. July 30, 1984).

determination of a hospital's base year costs and resulting errors in payment under the prospective payment rate on a prospective basis only; (3) HCFA's policy of not abiding by decisions of federal courts of appeals that rule in favor of providers, even with respect to cases in the same circuit; and (4) concerns about procedures before the PRRB.

1. Jurisdiction of the PRRB for Hospital Appeals Under the Prospective Payment System

Since the implementation of the prospective payment system, many hospitals have challenged the intermediary's calculation of the hospitals' base year costs for purposes of determining the hospital-specific portion of the prospective payment rate. Interpreting the phrase in section 1878(a)(1)(A), "a final determination of the Secretary as to the amount of payment,"⁴³⁰ the PRRB initially acknowledged jurisdiction over appeals of base year cost issues where the hospital had received a "Final Notice of Base Period Cost and Target Amount per Discharge" from the intermediary.⁴³¹ In May 1984 the Secretary issued HCFAR-84-1, reversing the PRRB's position that it had jurisdiction in these cases and ruling that the PRRB cannot assume jurisdiction over such determinations until (1) the end of the cost reporting period; and (2) the intermediary has issued a final Notice of Program Reimbursement (NPR) for that year.⁴³² Thus, this policy significantly postpones the time when errors in the calculation of the hospital-specific portion of the prospective payment rate can be appealed.

Many hospitals have challenged this HCFA ruling in court. The United States District Court for the District of Columbia consolidated its cases on this issue in *Tucson Medical Center v. Heckler*, granted summary judgment for the hospitals, and ordered the requested relief.⁴³³ On July 8, 1986, in *Washington Hospital Center v. Bowen*,⁴³⁴

430. Social Security Act, 42 U.S.C. § 1395oo(a)(1)(A) (1982 & Supp. II 1984).

431. HCFA interprets the phrase "final determination of the Secretary" in section 1878(a) of the Social Security Act to mean the intermediary's final determination of the total amount of payment due the hospital for the cost reporting period at issue. 42 C.F.R. § 405.1801(a)(1)(ii)-(iii) (1986). By regulation, the intermediary must provide a hospital with a notice of program reimbursement (NPR) that reports final payment for each annual cost reporting period. *Id.* § 405.1803.

432. HCFAR-84-1, 49 Fed. Reg. 2241 (1984). Final notice of program reimbursement usually does not occur until more than one year after the end of the cost reporting year.

433. 611 F. Supp. 823 (D.D.C. 1985), *aff'd sub nom.*, *Washington Hosp. Center v. Bowen*, 795 F.2d 139 (D.C. Cir. 1986).

434. 795 F.2d 139 (D.C. Cir. 1986); *accord* *St. Francis Hosp. v. Bowen*, 802 F.2d 697 (4th Cir. 1986); *Providence Hosp., Inc. v. Bowen*, [1986-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 35,430 (N.D. Ohio Feb. 13, 1986); *Medical Center*

the United States Court of Appeals for the District of Columbia Circuit affirmed the district court's decision in *Tucson Medical Center*.⁴³⁵

The court was persuaded that Congress had recognized that the prospective payment system established a final price per case before payment rather than a payment to hospitals retrospectively, and thus Congress had modified its jurisdictional requirements in section 1878(a)(1) for appeals of the hospital-specific portion of the prospective payment rate. This decision is in accord with the decisions of twelve other cases ruling against the HCFA's position on this issue.⁴³⁶

2. *Retrospective Correction of Errors in Prospective Payment Rates*

HCFA regulations provide that the intermediary's determination of the base year costs for calculating payment under the prospective payment system is "final and may not be changed after the first day" of the hospital's first year under the system, except if the provider wins a final judicial or administrative decision for its base year.⁴³⁷ In such event, the regulations provide that the intermediary may recalculate the base year costs and the Medicare payments for years after the administrative or judicial decision.⁴³⁸ Changes in the base year costs mandated by an administrative or judicial rule in favor of the fiscal inter-

Hosp. v. Bowen, [1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,920 (M.D. Fla. 1985), *appeal pending*, No. 86-3026 (11th Cir. 1987); Sunshine Health Center v. Bowen, [1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,858 (C.D. Cal. 1985), *appeal pending*, No. 85-6368 (9th Cir. 1987); Episcopal Hosp. v. Bowen, [1987-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 35,852 (E.D. Pa. Sept. 25, 1986).

435. *Id.* at 145. In an extensive analysis of the statutory provisions in section 1878 and section 1886, as well as the legislative history, Judge Wald concluded that "[t]he effect of the new language in the opening paragraph of § 1395oo(a), contrary to the Secretary's interpretation, is to eliminate the requirement that PPS recipients file a cost report prior to appeal."

436. *See, e.g.*, Greenville Hosp. Sys. v. Heckler, No. 85-1860 (4th Cir. Dec. 18, 1985); City of Lincoln v. Heckler, No. CV85-L-338 (D. Neb. Dec. 26, 1985); South-eastern Palm Beach County Hospital District v. Heckler, [1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 35,047 (S.D. Fla. Nov. 26, 1985); North Broward Hosp. Dist. v. Heckler, No. 85-6185-Civ-King (S.D. Fla. Nov. 8, 1985); Good Samaritan Hosp. v. Heckler, No. 84-L-459 (D. Neb. Nov. 1, 1985); St. Francis Hosp. v. Heckler, [1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,918 (S.D. W. Va. Sept. 30, 1985); Medical Center Hosp. v. Heckler, [1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,920 (M.D. Fla. Sept. 23, 1985); Doctors Gen. Hosp., Inc. v. Heckler, 613 F. Supp. 1036 (S.D. Fla. 1985); Charter Medical Corp. v. Heckler, No. C84-116-A (N.D. Ga. Mar. 20, 1985); Redbud Hosp. Dist. v. Heckler, [1984-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,085 (N.D. Cal. July 10, 1984).

437. 42 C.F.R. § 412.72(g)(3)(D) (1986).

438. *Id.* § 412.72(a)(3)(ii).

mediary are made retrospectively.⁴³⁹ HCFA has justified its policy on grounds that, by statute and legislative history, the fiscal intermediary must make the determination of the initial base year costs on the best available data. Having done so, retrospective recalculation is not required for the base year and payment.⁴⁴⁰

Hospitals have been quite concerned about this policy. Combined with the requirement in HCFAR-84-1 that hospitals can only initiate an appeal after receiving an NPR, this policy effectively precludes a hospital from obtaining any financial relief for an intermediary's error in calculating its base year costs and payment rates from 1983 to the date of the administrative or judicial decision determining that there has been an error in the calculations of base year costs.⁴⁴¹ There have been several cases challenging this policy which have ruled in favor of the hospitals.⁴⁴²

3. HHS Non-Acquiescence with Judicial Decisions

As in other Social Security Act programs,⁴⁴³ HHS has refused to follow United States circuit courts of appeals decisions favorable to providers, even those arising in the same circuit. Consequently, hospitals are required to bring separate appeals on issues that have been

439. PRM-1 § 2802E, reprinted in 1 Medicare & Medicaid Guide (CCH) ¶ 4255.

440. Preamble to Proposed Rule, 49 Fed. Reg. 27,422, 27,428 (1984); see H.R. REP. NO. 47, 98th Cong., 1st Sess. 182 (1983) (stating congressional intent that fiscal intermediaries make determinations using best available data).

441. *Medicare Provisions: Hearings on S. 1158 Before the Subcomm. on Health of the Senate Comm. on Finance*, 99th Cong., 1st Sess. 79 (1985) (statement of the Catholic Health Association of America). This statement illustrates the schedule for the intermediary's action on a hospital's cost report and indicates that the notice of program reimbursement is generally issued one year after the hospital files its cost report. It takes another year after issuance of the NPR for the PRRB to decide the case — nearly four years after the beginning of the cost reporting year at issue. *Id.*

442. *St. Francis Hosp. v. Heckler*, [1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,918 (S.D. W. Va. Sept. 30, 1985), *aff'd in part, rev'd in part*, [1987-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 35,881 (4th Cir. Oct. 1, 1986); *Charter Medical Corp. v. Heckler*, 604 F. Supp. 638 (M.D. Ga. 1985), *rev'd*, 788 F.2d 728 (11th Cir. 1986) (reversing on jurisdictional grounds).

443. HHS's non-acquiescence in circuit court of appeals decisions has been a controversial practice, particularly with the Social Security Disability Insurance Program, and has commanded the attention of Congress as well as the scholastic community. See *Judicial Review of Agency Action: HHS Policy of Nonacquiescence: Oversight Hearings Before the Subcomm. on Administrative Law and Governmental Relations of the House Comm. on the Judiciary*, 99th Cong., 1st Sess. (1985); National Senior Citizens Law Center, *Steiberger v. Heckler: A Careful Analysis of HHS's Policy of Nonacquiescence*, 19 CLEARINGHOUSE REV. 1165 (1986); Note, *Agency Nonacquiescence: Implementation, Justification, and Acceptability*, 42 WASH. & LEE L. REV. 1233 (1985); Kuhl, *The Social Security Administration's Nonacquiescence Policy*, 4 DET. C.L. REV. 913 (1984).

decided in favor of providers by a number of courts of appeals. HHS's non-acquiescence policy with respect to the Medicare program is exemplified by HCFA's actions in response to court decisions in favor of hospitals on the labor and delivery room day policy.

The American Hospital Association coordinated a group appeal to the PRRB on the labor and delivery room day issue. The PRRB ruled in favor of the hospitals on this issue on August 19, 1980. But in a decision dated October 17, 1980, the Deputy Administrator reversed the PRRB's decision.⁴⁴⁴ The hospitals appealed this decision to the United States District Court for the District of Columbia in order to get a quick and final resolution of this issue in the court to which all hospitals had a right to appeal.⁴⁴⁵ In *St. Mary of Nazareth Hospital v. Schweiker*,⁴⁴⁶ the district court affirmed the Deputy Administrator. However, the United States Court of Appeals for the District of Columbia Circuit reversed this decision and ruled that the labor and delivery room day policy was arbitrary, capricious, and in violation of the Medicare statute.⁴⁴⁷ Since that decision, the five other courts of appeals that have heard cases on this issue have rejected the Secretary's policy.⁴⁴⁸

Despite uniform courts of appeals decisions continually rejecting various HCFA rationales for this policy, HCFA refuses to abandon this policy, even in those circuits where the court of appeals has invalidated the policy. Rather, HCFA requires each individual hospital to challenge the policy and provides relief only under court order. Further, as in the case of *St. Mary of Nazareth Hospital v. Heckler*, HCFA accorded relief only for the cost reporting year appealed in the case and

444. PRRB Decision No. 80-D67 (Aug. 19, 1980), *rev'd*, HCFA Dep. Admin. Dec. (Oct. 17, 1980).

445. *Medicare Appeals Provisions: Hearings on S. 1158 Before the Subcomm. on Health of the Senate Comm. on Finance*, 99th Cong., 1st Sess. 88 (1985) (statement of the Catholic Health Association of America).

446. [1981-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 31.594 (D.D.C. Nov. 9, 1981).

447. 718 F.2d 459 (D.C. Cir. 1983).

448. *See, e.g.*, *Community Hosp. of Roanoke Valley v. HHS*, 770 F.2d 1257 (4th Cir. 1985) (finding Medicare accounting practices governing hospital labor and delivery room services irrational and contrary to Medicare law and regulation); *Central DuPage Hosp. v. Heckler*, 761 F.2d 354 (7th Cir. 1985) (deciding labor and delivery room policies irrational for purposes of Medicare reimbursement); *Mt. Zion Hosp. and Medical Center v. Heckler*, 758 F.2d 1346 (9th Cir. 1985) (holding that labor and delivery room patients may not be counted for census under Medicare statute and regulations); *Beth Israel Hosp. v. Heckler*, 734 F.2d 90 (1st Cir. 1984) (determining as irrational HHS policy apportioning labor and maternity patients' costs not incurred without including cost actually incurred); *Baylor University Medical Center v. Heckler*, 730 F.2d 391 (5th Cir. 1984) (holding labor and delivery room patients not includable in midnight census for purposes of medicare reimbursement).

not for years before or after.⁴⁴⁹ Finally, it should be emphasized that this is not the only Medicare issue where HHS has not acquiesced in a court of appeals decision, even with respect to providers in the same circuit.⁴⁶⁰

4. PRRB Role and Procedures

Over the years, both HCFA and provider groups have raised concerns in four areas about the PRRB and its effectiveness in serving as a credible adjudicator of provider payment disputes: (1) the nature of the PRRB's role in the payment appeals process; (2) the administrative exhaustion requirement when the PRRB has no authority to decide the disputed issue; (3) specific problems with PRRB hearing procedures; and (4) procedures for group appeals by providers. The authority and role of the PRRB has generated the greatest concern and is the most important, particularly if the PRRB is assigned new adjudicative responsibilities in the future. This concern is shared by providers, HCFA, and the PRRB, although for quite different reasons.

The PRRB is an independent tribunal separate from the Medicare program. It was never intended, however, to be the final decisionmaker on program policy, as is evidenced by the authority Congress accorded the Secretary to reverse or modify PRRB decisions.⁴⁵¹ Providers argue that the PRRB is not truly independent due to the Secretary's authority. This concern has been aggravated by the HCFA Deputy Administrator's practice of reversing a large proportion of Board decisions in favor of providers.⁴⁵² In 1983 HCFA endeavored to alleviate providers' concerns by promulgating regulations outlining the criteria for when the Deputy Administrator would review and change a PRRB decision.

449. See *Medicare Appeals Provisions: Hearings on S. 1158 Before the Subcomm. on Health of the Senate Comm. on Finance*, 99th Cong., 1st Sess. 89 (1985) (statement of the Catholic Health Association of America) (noting HHS's ability to temporarily deny hospitals favorable treatment from precedent established in *St. Mary's of Nazareth Hospital*).

450. For an example of HCFA refusing to follow the decision of the United States Court of Appeals for the Fifth Circuit, see *Presbyterian Hosp. of Dallas v. Schweiker*, 638 F.2d 1381 (5th Cir. 1981), *cert. denied*, 454 U.S. 940 (1981) (ruling cost of providing free care pursuant to Hill-Burton hospital construction and survey program constituted allowable cost for reimbursement purposes under Medicare program).

451. Social Security Act, 42 U.S.C. § 1395oo(f) (1982 & Supp. II 1984).

452. See The American Bar Association, *Report and Recommendations from the American Bar Association House of Delegates* (Aug. 6, 1980) (reporting that from 1975 until 1979, Secretary reversed 41.7% of all issues Board decided in favor of providers). HCFA reports that between January 1976 and October 1983, the HCFA Deputy Administrator declined to review the Board's decision in about 54% of issues decided by the Board and has affirmed about 25% and reversed or modified about 21%. Preamble to Final Rule, 48 Fed. Reg. 45,766 (1983).

The regulations also proscribed *ex parte* contacts by HCFA staff and the Deputy Administrator regarding a PRRB decision.⁴⁵³

HCFA has indicated dissatisfaction with the PRRB chiefly because it makes decisions beyond the scope of its statutory authority. In its decisions reversing the PRRB, HCFA has stated emphatically that the PRRB decisions as to the validity of the Medicare statute or regulations are beyond the scope of its statutory authority.⁴⁵⁴ These decisions reflect HCFA's perception that the PRRB is generally too sympathetic to providers and does not fully appreciate the statutory and regulatory parameters in which it operates.⁴⁵⁵

The PRRB also shares the concern about its independence, but has a radically different perspective than the providers or HCFA. The PRRB has a strained relationship with HCFA and believes that HCFA has denied it the requisite resources to do its job effectively. Members of the PRRB have publicly expressed their concerns about the PRRB's relationship with HCFA and its ability to act independently of HCFA, as it believes Congress contemplated.⁴⁵⁶ To enhance its independence,

453. 48 Fed. Reg. 45,774 (1983) (codified at 42 C.F.R. § 1875 (1986)); *see supra* notes 261-63 and accompanying text (discussing criteria for reversing Board's decision).

454. *See, e.g.*, HCFA Dep. Admin. Dec. (Feb. 15, 1980), *rev'g*, PRRB Dec. No. 79-D95 (Dec. 15, 1979) (discussing return on equity for nonprofit hospitals); HCFA Dep. Admin. Dec. (Oct. 17, 1980), *rev'g*, PRRB Dec. No. 80-D67 (Aug. 19, 1980); HCFA Dep. Admin. Dec. (Sept. 12, 1977), *modifying*, PRRB Dec. No. 77-D50 (July 14, 1977) (discussing labor and delivery room issue); *St. Mary of Nazareth Hosp. Center v. Schweiker*, 718 F.2d 459, 465 n.11 (D.C. Cir. 1983) (canvassing decisions on labor and delivery issue).

455. In many of the PRRB decisions, the PRRB definitely based its decision on an interpretation of the statute, and in one case the Constitution, that differed from the position of HHS. *See, e.g.*, PRRB Dec. No. 79-D95 (Dec. 15, 1979), *rev'd*, HCFA Dep. Admin. Dec. (Feb. 15, 1980) (ruling HHS did not have to give deference to PRRB's decision); *Indiana Hosp. Ass'n v. Schweiker*, 544 F. Supp. 1167 (S.D. Ind. 1982) (holding Secretary of HHS has ultimate responsibility and decisionmaking authority under Medicare program), *aff'd sub nom.*, *St. Francis Hosp. Center v. Heckler*, 714 F.2d 872 (7th Cir. 1983), *cert. denied*, 465 U.S. 1022 (1984).

456. In a 1983 letter to congressional staff, three PRRB members stated:

Clearly, resources (personnel, equipment and material) are the most critical problem. The history of the Board supports our conclusion that the only way the Board will be able to fulfill its purpose is to be an agency independent of the Department of Health and Human Services as well as the Health Care Financing Administration (HCFA). From its inception, the Board has operated as an orphan within HCFA, with a history of unresponsiveness and inadequate support. Clearly, the Board must be independent. In fact, such independent status would also result in the elimination of the Secretary's own motion review. The delegation of this review process to HCFA has effectively impaired the providers' right to due process. This situation is exacerbated by the *ex parte* communication between the Deputy Administrator Attorney Advisor [the HCFA officer that handles PRRB decisions for the Deputy Administrator] and others within HCFA, such as those who promulgate policy, when reviewing individual cases

as well as its effectiveness, some board members have suggested longer terms for Board members.⁴⁵⁷

The second area of concern is the requirement that providers appeal all payment issues to the PRRB before proceeding to federal court. This requirement includes challenges to the validity of Medicare statutory or regulatory provisions over which the PRRB has no authority. This exhaustion requirement delays judicial consideration of the validity of new Medicare regulations, many of which have an immediate and substantial impact on providers. Congress endeavored to address this problem with the expedited review procedures in section 1878(f) of the Social Security Act.⁴⁵⁸ Providers have argued that this procedure has not significantly expedited Medicare appeals because of the delays in the PRRB's determination of whether or not it has jurisdiction in the case.⁴⁵⁹ The third area of concern involves minor, but important, problems with PRRB procedures.⁴⁶⁰ Many of these concerns are shared by both providers and HCFA. One problem of concern is the timeliness of PRRB hearings and decisions. The PRRB now has a backlog of approximately 2,750 cases, and it takes the PRRB almost one year after the NPR to make its decision. The PRRB reports that the problem of delay may be abating since many cases are now being settled prior to hearings. Thus, providers who want hearings can have them virtually upon request.⁴⁶¹

Another problem for both providers and HCFA is determining who represents the Medicare program's position at various steps of the appeals process. The fiscal intermediary represents the Medicare program

after the Board has concluded the hearing and completed the evidentiary record. Letter from Betty Adaniya Kraus, Paul Morton Ganeles, and Richard A. Dudgeon, members of the PRRB, to Sandra Casber and Kevin Yow, staff of the House Comm. on Ways and Means (undated, 1983).

457. *Id.* Three members of the Board have suggested twelve-year terms, as opposed to the current three-year terms. *Id.*

458. Social Security Act, 42 U.S.C. § 1395oo(f) (1982 & Supp. II 1984).

459. See *Alexandria Hosp. v. Bowen*, No. 85-676-R (W.D. Va. Mar. 17, 1986) (ruling that 30-day period after which expedited appeal can go directly to court, if PRRB fails to act, does not commence until PRRB decides whether it has jurisdiction).

460. These include the PRRB's decisionmaking through use of internal manuals and guidelines that are not promulgated as rules under the Administrative Procedure Act, not sufficiently stating facts on which a decision is based, and concerns that the PRRB has exercised its rulemaking authority with respect to section 1878(g) procedures unfairly and in a fashion intended to discourage appeals. See Peterson, *Legislative Changes Urged Regarding Medicare Appeals*, HEALTH L. VIGIL (May 3, 1985). Another concern is the lack of a modern docketing system at the PRRB. The PRRB Chairman maintains that the PRRB docketing and notification systems could be computerized at a cost of \$200,000, which, in his judgment, would enhance the PRRB's productivity enormously.

461. See Owens, *supra* note 268 (reporting recent availability of hearings).

before the PRRB. The HHS Office of General Counsel represents HCFA if the case is appealed to federal court. This division in representation for HCFA's position before the Board and in federal court has sometimes resulted in an insufficient record on HCFA policies on appeal.⁴⁶²

C. Hearing Procedures Under Part B

Since the inception of the Medicare program, beneficiaries and providers have challenged the fairness of hearing procedures for coverage and payment determinations under Part B.⁴⁶³ The primary concern is the preclusion of administrative and judicial review of the carrier's decision made in the fair hearing discussed in Chapter VI. Beneficiaries have, however, challenged several other aspects of the hearing procedures under Part B.

In *Gray Panthers I*,⁴⁶⁴ the United States Court of Appeals for the District of Columbia Circuit ruled that the Due Process Clause of the fifth amendment, as interpreted in *Mathews v. Eldridge*,⁴⁶⁵ required additional formal hearing procedures and additional protections for beneficiaries in appeals of disputed Part B claims under \$100. Although the court rejected the plaintiff's argument that procedural due process required a formal oral hearing, the court ruled that the extant procedures for appeals under Part B did not comport with due process requirements. These hearings failed because they did not permit an oral interview or consultation with an official who would inform the beneficiary about the basis of the denial.⁴⁶⁶ The court ruled that an

462. *Id.*

463. See, e.g., *Armstrong v. Aetna Life Insurance Co.*, [1982 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 32,082 (D. Or. June 25, 1982); *Davis v. HEW*, 416 F. Supp. 448 (S.D.N.Y. 1976) (reporting beneficiary challenged validity of hearing procedure for disputed Part B claims); *United States v. Lapin*, 518 F. Supp. 735 (D. Md. 1979) (reporting case in which government sued for recovery of Part B overpayment pursuant to ALJ's determination).

464. 652 F.2d 146 (D.C. Cir. 1980), *rev'g and remanding*, 466 F. Supp. 1317 (D.D.C. 1979), *reh'g. on remand*, [1982 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 32,144 (D.D.C. Sept. 10, 1982); *Gray Panthers v. Schweiker*, 716 F.2d 23 (D.C. Cir. 1983), *remanding*, [1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,981 (D.D.C. Nov. 4, 1985) (approving parties' stipulation regarding Part B claims of less than \$100); [1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 35,140 (D.D.C. Feb. 14, 1986) (ruling oral hearings not required for Part A claims of less than \$100).

465. 424 U.S. 319, 332-35 (1976).

466. 652 F.2d at 167-72. These deficiencies were compounded by the lack of information about the basis of the denial contained in the EOMB. See *supra* notes 362-77 and accompanying text (discussing nature and extent of information given to beneficiaries and resultant lack of appeals because of lack of knowledge).

adequate hearing for small Part B claims required timely notice to the claimant of the evidence relied on by the carrier to deny the claim and an opportunity to present evidence, either oral or written. In addition, after the hearing the claimant should receive explanation of the action taken on the decision.⁴⁶⁷

After considerable litigation on the question of what due process requires for small Part B claims,⁴⁶⁸ the Secretary agreed that carriers would be required to improve procedures for giving beneficiaries specific information about the disposition of their claim. This improved procedure included an opportunity to talk with a knowledgeable and responsible official regarding the claim through a toll-free telephone system, as well as appeal rights.⁴⁶⁹

In *Schweiker v. McClure*,⁴⁷⁰ the Supreme Court considered another challenge to Part B appeal procedures for claims of \$100 or more. In this case, plaintiffs claimed that the practice of having carrier employees or appointees make final, unappealable decisions on Part B claims in fair hearings constituted a violation of beneficiaries' rights to due process of law under the fifth amendment. Specifically, plaintiffs claimed that beneficiaries were entitled to a hearing before an ALJ. A unanimous Supreme Court concluded that carrier Part B hearing officers, who were employed or appointed by the carrier, were not biased absent a showing of some disqualifying interest.⁴⁷¹ The fact of employment or appointment by the carrier did not, without "proof of financial interest on the part of the carriers," rise to the level of a disqualifying interest.⁴⁷² The Court disagreed with plaintiffs' argument that beneficiaries were entitled to a hearing before an ALJ or entitled to judicial review as a matter of due process.⁴⁷³

467. 652 F.2d at 172.

468. *Gray Panthers v. Schweiker*, 652 F.2d 146 (D.C. Cir. 1980), *reh'g on remand*, [1982 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 32,144 (D.D.C. Sept. 10, 1982), *remanded*, 716 F.2d 23 (D.C. Cir. 1983), *reh'g on remand*, [1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,981 (D.D.C. Nov. 4, 1985) (approving parties' stipulation regarding Part B claims of less than \$100); [1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 35,140 (D.D.C. Feb. 14, 1986) (ruling oral hearings not required for Part A claims of less than \$100).

469. *Gray Panthers v. Heckler*, [1986-1 Transfer Binder] Medicare Medicaid Guide (CCH) ¶ 34,981 (D.D.C. Nov. 4, 1985).

470. 456 U.S. 188 (1982).

471. *Id.* at 196.

472. *Id.* at 197.

473. The Court concluded that "[a]ppellees simply have not shown that the procedures prescribed by Congress or the Secretary are not fair or that different or additional procedures would reduce the risk of erroneous deprivation of Part B benefits." *Id.* at 200.

In *David v. Heckler*,⁴⁷⁴ beneficiaries alleged that many of the fair hearing procedures did not meet due process requirements. Specifically, the fair hearing procedures were alleged to be deficient in three areas: (1) the lack of subpoena power to give beneficiaries leverage in getting the treating physicians to supply more detailed information about the medical services provided; (2) ex parte communications between the hearing officer and employees; and (3) the lack of adequate qualifications and lack of independence of the hearing officers. The district court rejected these arguments. The court found, however, that ex parte contacts were improper, but were already proscribed by HHS regulations and did not arise frequently enough to warrant additional relief in this case.⁴⁷⁵ Despite these court decisions, there remains concern about Part B hearing procedures and the statutory preclusion of administrative and judicial review of coverage and payment determinations under Part B.

With the provision of administrative and judicial review of carrier determinations of \$500 or more, the adequacy and fairness of carrier hearing procedures should not be as serious a concern as it is with respect to claims between \$100 and \$500. The chief issue regarding administrative appeals under Part B now is how HHS should organize the administrative law judges charged with hearing Part B and other Medicare claims. The question is whether HHS should create a separate division of ALJ's within HCFA to handle all Medicare administrative appeals, as suggested by the House Ways and Means Committee, or leave these responsibilities within the ALJ corps in the Social Security Administration. HHS has established an internal task force and is currently looking into this question.

VI. AVAILABILITY OF ADMINISTRATIVE AND JUDICIAL REVIEW

Congress has carefully prescribed the circumstances where administrative and judicial review of medicare coverage and payment disputes of beneficiaries and providers is available and in several instances has expressly precluded administrative and judicial review. Precluded are: (1) certain issues respecting beneficiary and provider coverage and payment disputes under Part B;⁴⁷⁶ and (2) certain payment issues for hos-

474. 591 F. Supp. 1033 (E.D.N.Y. 1984).

475. Although the Court did not grant plaintiff's relief on the fair hearing issue, the Court found a due process violation existed for insufficient information available to medicare beneficiaries on which to challenge adverse determinations. HHS was instructed to correct the notice procedure and to cooperate more fully with beneficiaries by providing additional information when requested. *Id.* at 1047-48.

476. See *supra* notes 277, 294-301 and accompanying text (discussing preclusion of

pitals under the prospective payment system.⁴⁷⁷ In addition, Congress has expressly barred federal question jurisdiction for claims arising under the Social Security Act. Thus, judicial review is unavailable for claims arising under the Social Security Act unless the Act provides otherwise.⁴⁷⁸ Beneficiaries and providers maintain that preclusion of administrative and judicial review under the Medicare program is unfair. Nevertheless, Congress has consistently retained these preclusions, and the Supreme Court and other federal courts have generally upheld them.

A. Administrative and Judicial Review of Certain Part B Coverage and Payment Disputes

As noted above, initially section 1869 accorded administrative and judicial review only to beneficiaries under Part A, and section 1842 required carriers to provide a fair hearing to beneficiaries in coverage disputes.⁴⁷⁹ Beneficiaries and providers have challenged these preclusions in court with little success.⁴⁸⁰ Congress, in retaining the statutory preclusion of administrative and judicial review, contends that Part B claims would flood the courts with small claims that provide little actual benefit to beneficiaries.⁴⁸¹

The Supreme Court recently decided several cases that raised the issue of whether administrative and judicial review is available for appeals under Part B. In *United States v. Erika, Inc.*,⁴⁸² the sole issue

judicial review under Social Security Amendments of 1965 and administrative review under Omnibus Budget Reconciliation Act of 1986).

477. See *supra* notes 242 & 276 and *infra* notes 479-508 and accompanying text (discussing strict limitation as to what may be appealed).

478. Social Security Act, 42 U.S.C. § 405(h) (1982 & Supp. II 1984).

479. See *supra* notes 188-210 and accompanying text (discussing historical development of Medicare appeals system).

480. See, e.g., *Herzog v. Secretary of HEW*, 686 F.2d 1154 (6th Cir. 1982) (holding court lacked jurisdiction to review Part B reimbursement denial); *Drennan v. Harris*, 606 F.2d 846 (9th Cir. 1979) (holding lack of jurisdiction to review adverse benefit amount determination and due process claim); *Pushkin v. Califano*, 600 F.2d 486 (5th Cir. 1979) (dismissing optometrists' challenge to regulation precluding Medicare coverage of optometric exams on grounds of lack of jurisdiction); *Prett v. Nationwide Insurance Co.*, 548 F.2d 1129 (4th Cir. 1977) (holding district court lacked subject matter jurisdiction over infringement of pediatricist's constitutional rights pursuant to Medicare denial of claims); *St. Louis Univ. v. Blue Cross Hosp. Serv.*, 537 F.2d 283 (8th Cir. 1976) (holding court precluded from reviewing university's claim challenge that denial of Part B claims violates due process and equal protection rights), *cert. denied*, 429 U.S. 977 (1976).

481. See *supra* notes 188-195 and accompanying text (outlining historical procedure of claims under Part B).

482. 456 U.S. 201 (1982). A major distributor of kidney dialysis supplies brought suit in the United States Court of Claims, seeking reimbursement for Part B services

before the Supreme Court was whether the court of claims had jurisdiction in a Part B case. The Supreme Court concluded that the court of claims did not have jurisdiction because Congress had specifically precluded judicial review of a hearing officer's adverse decision on the amount of Part B payments under section 1842(b)(3)(C).⁴⁸³

After careful review of the legislative history of section 1842(b)(3)(C), the Court was persuaded that Congress clearly intended to preclude administrative and judicial review of Part B claims. Congress reaffirmed this intention, stated the Court, when it amended section 1869 in the Social Security Amendments of 1972⁴⁸⁴ to distinguish more clearly between appeals over benefit entitlements and appeals over benefit amounts in order "to avoid overloading the courts with quite minor matters."⁴⁸⁵

Despite this Supreme Court decision, beneficiaries and providers have continued to press for administrative and judicial review of Part B claims. They are concerned that carrier coverage and payment decisions are consistently inaccurate and result in substantial underpayment of Part B claims.⁴⁸⁶ In the November 1985 Senate Finance Committee hearings on Medicare appeals, deficiencies in the Part B hearing procedures and, specifically, the statutory preclusion of administrative and judicial review of carrier decisions on coverage and payment disputes dominated the discussion and were the main focus of section 1551, the Fair Medical Appeals Act, which was being considered at those hearings.⁴⁸⁷ Several witnesses testified that recent developments in the Medicare program justified a reformed appeals procedure for Part B claims.⁴⁸⁸ Specifically, the Part B program now includes highly sophisticated and expensive services provided on an outpatient basis.

after its carrier had ruled in a fair hearing under section 1842(b)(3)(C) to affirm the carrier's initial calculation of the payment due the plaintiff. The court of claims had ruled that the suit was within the jurisdictional grant of the Tucker Act, 28 U.S.C. § 1491 (1982 & Supp. II 1984), and remanded the case to the carrier for a redetermination of payment on the basis of its opinion.

483. The Court did not reach the question of whether the bar to federal question jurisdiction in section 205(h) applied in this instance. 456 U.S. at 206 n.6.

484. Social Security Amendments of 1972, § 2990 (codified as amended at 42 U.S.C. § 1395ff (1982)).

485. 456 U.S. at 209 (quoting 118 CONG. REC. 33,992 (1972) (statement of Sen. Bennett)).

486. See General Accounting Office, *Medicare Part B Beneficiary Appeals Procedure* (HRD-85-79 June 28, 1985); *Medicare Appeals Provisions: Hearings on S. 1158 Before the Subcomm. on Health of the Senate Comm. on Finance*, 99th Cong., 1st Sess. (1985).

487. See *Medicare Appeals Provisions: Hearings on S. 1158 Before the Subcomm. on Health of the Senate Comm. on Finance*, 99th Cong., 1st Sess. (1985).

488. *Id.*

Thus, it was argued, the claims under Part B involve substantially greater sums than originally anticipated at the inception of the Medicare program. Further, witnesses testified that the size and volume of Part B claims will increase further as Medicare beneficiaries receive more of their medical care on an outpatient basis.⁴⁸⁹ HHS has consistently opposed providing administrative and judicial review of Part B claims primarily because of the associated expense.⁴⁹⁰ Appeals would significantly increase the workload of the Social Security ALJ corps, which are faced with a large volume of appeals of disability program claimants as a result of the Social Security Disability Benefits Reform Act of 1984.⁴⁹¹ Similarly, HHS has opposed judicial review for Part B claims on grounds that this would result in increased costs for the Medicare program. HHS also argues that extant hearing procedures are fair and adequate.⁴⁹²

It is essential, however, to appreciate that Congress retained significant barriers to the administrative and judicial review of Part B claims to the extent that, as a practical matter, there may be few Part B claims for which administrative and judicial review is actually available. Indeed, given these limitations, only challenges to coverage decisions specific to the individual beneficiary and not a matter of policy, as well as challenges to payment amounts and post-1981 payment methodologies, remain as Part B claims.

Review of national coverage determinations is limited to whether the

489. *Id.* The American Bar Association endorses the need for administrative and judicial review of Part B coverage and payment determinations. Judicial decisions upholding the statutory preclusion of judicial review, coupled with regulatory requirements that carrier-appointed hearing officers must comply with HHS regulations, interpretative rules, and policy statements, 42 C.F.R. § 405.860 (1986), "result in Medicare beneficiaries being conclusively bound by actions of HHS, no matter how arbitrary and illegal those actions might be." *Medicare Appeals Provisions: Hearings on S. 1158 Before the Subcomm. on Health of the Senate Comm. on Finance, 99th Cong., 1st Sess. 193 (1985)* (statement of the American Bar Association); see also *ABA Report and Recommendations*. This position reaffirms a long-standing ABA position in favor of administrative and judicial review of Part B claims. *Id.*

490. In the 1985 Senate Finance Committee hearings on Medicare appeals provisions, HCFA reported that an estimated 16,000 Part B appeals would meet the jurisdictional requirements for ALJ review under S. 1551 at a cost of between \$11 million and \$17 million to the Medicare program. *Medicare Appeals Provisions: Hearings on S. 1158 Before the Subcomm. On Health of the Senate Comm. on Finance, 99th Cong., 1st Sess. 50 (1985)* (statement of Henry R. Desmarais, M.D., Acting Deputy Administrator, Health Care Financing Administration). Further, the HHS Office of General Counsel reports that it costs approximately \$550 to conduct an ALJ hearing.

491. Pub. L. No. 98-469, 97 Stat. 134 (1984).

492. *Medicare Appeals Provisions: Hearings on S. 1158 Before the Subcomm. On Health of the Senate Comm. on Finance, 99th Cong., 1st Sess. 40-52 (1985)* (statement of Henry R. Desmarais, Acting Deputy Administrator, Health Care Financing Administration).

Secretary made the determination in an arbitrary manner or without an adequate basis. National coverage determinations cannot be challenged on the basis that the Secretary failed to comply with APA notice and comment rulemaking procedures. Arguably, there may be some justification for the limitations on review of national coverage determinations in that these are essentially medical decisions establishing Medicare coverage policy on a national basis through a process eliciting medical input and consultation. It would thus be disruptive to the Medicare program for district courts to overturn these coverage policies without first giving HHS an opportunity to reconsider them.⁴⁹³

Limitations on challenges of national coverage determinations for failure to comply with APA notice and comment rulemaking procedures are more problematic, particularly over the long term. Questions have been raised among beneficiary groups and medical equipment manufacturers about the fairness of HHS procedures for making national coverage determinations and, particularly, the opportunities for public input in these determinations. As noted above, in *Jameson v. Bowen*⁴⁹⁴ HHS agreed in a settlement decree to publish a description of its process for making national coverage decisions by April 1, 1987. HHS is not, however, committed to developing or publishing *criteria* for making national coverage decisions by any specific date.⁴⁹⁵ HHS has recognized deficiencies in its procedures for making national coverage determinations and has commissioned a study of these procedures with a view to making reforms in the future.

On the other hand, there seems to be little justification other than administrative convenience for the limitation on administrative and judicial review of Part B payment methodologies adopted before 1981. The only other defensible justification for this statutory preclusion is maintaining the integrity of the payment system for physicians' and suppliers' services under Part B. Because of previous statutory preclusions of administrative and judicial review, this payment system has not been subject to effective challenge or judicial scrutiny since the inception of the Medicare program. Congress and HHS may be concerned that without this preclusion of review of pre-1981 payment policies, there would be a multitude of persuasive challenges that would necessitate changes in the payment methodology at a time when Congress and HHS are working on fundamentally restructuring the Part B program.

493. See *Heckler v. Ringer*, 466 U.S. 602 (1984) (recognizing advisability of giving Secretary such opportunity).

494. [1987-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 36,073 (E.C. Cal. Feb. 20, 1987).

495. *Id.*

B. Preclusion of Payment Issues for Hospitals Under the Prospective Payment System

Congress enacted rather extraordinary preclusions of administrative and judicial review of certain elements of the payment rates under the prospective payment system.⁴⁹⁶ In its original proposal for a prospective payment system, HHS maintained there should be no judicial review of any payment issue under the prospective payment system. HHS feared that allowing hospitals to appeal elements of hospital payment rates would lead to a judicial dismantling of the prospective payment system's rate structure. HHS stated its proposal for an expansive preclusion of judicial review in its 1982 report to Congress.⁴⁹⁷

Congress and HHS were both concerned with the effect on the integrity of the rate structure if hospitals could appeal any issue affecting payment rates under the prospective payment system. Congress, however, drew the line more narrowly than HHS. As a check on the Administration's authority to recalibrate DRG's and to set hospital payment rates, Congress created ProPAC to monitor and evaluate HHS's performance in setting payment rates. Congress mandated that ProPAC analyze the hospital payment rates and the DRG's independently of HHS and then advise HHS of its findings. Specifically, the Social Security Amendments of 1983 preclude administrative and judicial review of the establishment of DRG's, the methodology for classifying patient discharges into DRG's, and the appropriate weighting factors for DRG's.⁴⁹⁸ The House Ways and Means Committee stated,

496. Social Security Amendments of 1983, § 602(h) (codified as amended at 42 U.S.C. §§ 1395oo(g)(2), 1395ww(d)(7) (Supp. II 1984)).

497. The report stated that:

Payment amounts, exceptions, adjustments, and rules to implement the prospective payment system would not be subject to any form of judicial review. Retroactive adjustment of the payment rates, as might result from judicial review, is inimical to the basic purpose of a prospective system. Moreover, the delays inherent in the judicial process, when coupled with the likelihood of annual revisions in the rates of payment, could lead to chaotic results, in which rates for a previous period may be overturned by a court, or remanded to the Department for further consideration, even though different rates had superseded the contested rates. The prospect of continuous litigation and re-opened administrative proceedings related to supposedly prospective rates for past periods can be prevented by a complete preclusion of judicial review. The omission of judicial review follows the current statutory provisions related to determinations under Medicare Part B, where judicial review is also prohibited. As with any service sold to the Government, the remedy for providers dissatisfied with the rate offered is to convince the purchasing agency that a higher rate is appropriate, or failing that, to refrain from offering services to the Government.

Id. at 41.

498. Social Security Amendments of 1983, § 602(h)(3) (codified as amended at 42 U.S.C. § 1395oo(g) (Supp. III 1985)).

in a comment reflecting congressional concern over the integrity of the rate structure, that the statutory preclusion was necessary "because of the complexity of such action and the necessity of maintaining a workable payment system."⁴⁹⁹

Congress has expressly excluded from administrative or judicial review the factor used in a hospital's payment formula that ensures compliance with the so-called "budget neutrality" requirement. This requires that the prospective payment system result in aggregate Medicare payments equal to "what would have been payable" under the previous reimbursement methodology for Fiscal Year 1984 and Fiscal Year 1985.⁵⁰⁰ This adjustment is a factor created to ensure that the amount of outlier costs would not result in overall Medicare hospital expenditures in excess of the estimates of budgetary outlays for Fiscal Year 1984 and 1985.⁵⁰¹ While this "budget neutrality" requirement expired on September 30, 1985, its legality has yet to be judicially tested due to the time lag between the hospitals' closing of these fiscal years for accounting purposes and Medicare's notice of program reimbursement for that year — an event which, according to HCFAR-84-1, must transpire before an appeal can be made.⁵⁰²

As yet, no case has challenged the statutory preclusion of administrative and judicial review of the DRG prices or the budget neutrality factor, despite the fact that the hospital industry has repeatedly alleged that HHS has been unfair in updating the DRG prices and has ignored ProPAC's recommendations.⁵⁰³ One very plausible reason for the dearth of hospital challenges to this preclusion is that hospitals are doing quite well under the prospective payment system and showing record profits.⁵⁰⁴ Another probable reason is the difficulty a hospital would have in bringing a successful challenge to the methodology for establishing DRG weights and classification criteria absent egregious and obvious arbitrariness on the part of HHS in setting the DRG prices.

Perhaps more important for hospitals is HCFA's delegation of certain issues for adjudication to PRO's, i.e., disputes over "outliers" and

499. H.R. REP. NO. 25, 98th Cong. 2d Sess. pt. 1 at 143.

500. Social Security Amendments of 1983, § 601(e) (codified as amended at 42 U.S.C. § 1395ww(e)(1)(A) (Supp. III 1985)).

501. Tax Equity and Fiscal Responsibility Act of 1982; Social Security Amendments of 1983, § 601(e) (codified as amended at 42 U.S.C. § 1395ww(d)(1)(F) (Supp. III 1985)).

502. See *supra* note 435 and accompanying text (discussing Judge Wald's comment on cost reporting and time for appeal).

503. See *supra* notes 378-87 and accompanying text (discussing setting of rates under prospective payment system).

504. See *supra* notes 160-62 and accompanying text (discussing financial gains for hospital industry).

errors in DRG coding for particular cases, and the lack of administrative or judicial review of these determinations.⁵⁰⁵ The decision of a PRO with respect to a DRG classification can have important financial implications for hospitals, and yet a hospital has no recourse other than PRO reconsideration for an adverse determination.

Hospitals have complained about this lack of review, but as yet no suits have been filed challenging this arrangement.⁵⁰⁶ In an earlier constitutional challenge to the PSRO program, *Association of American Physicians and Surgeons v. Weinberger*,⁵⁰⁷ plaintiff physicians argued that the statutory delegation of adjudicative authority over physicians to private organizations was inherently biased against physicians because of the organizations' contractual relationship with HHS and their economic self-interest. The court, however, rejected these claims.⁵⁰⁸

C. Jurisdictional Bar to Judicial Review Under the Social Security Act

Both beneficiaries and providers disagree with the strict requirement that claimants exhaust all administrative remedies in challenges to the validity of a regulation, program directive, or HHS policy because of the bar to federal question jurisdiction in section 205(h) for any issue associated with a claim. They argue that this jurisdictional bar as interpreted in *Weinberger v. Salfi*,⁵⁰⁹ which held that the bar applies even with respect to an associated constitutional claim, imposes unreasonable administrative exhaustion requirements on challenges to the validity of statutory and regulatory provisions that administrative tribunals have no authority to adjudicate.⁵¹⁰

505. See *supra* notes 273-76 and accompanying text (discussing PRO appeals for hospitals).

506. *Medicare Appeals Provisions: Hearings on S. 1158 Before the Subcomm. On Health of the Senate Comm. on Finance, 99th Cong., 1st Sess. 112-115 (1985)* (statement of Catholic Health Association of America) (stating purposes of validation review and reasons PRO's must conduct DRG validation reviews).

507. 395 F. Supp. 125 (N.D. Ill. 1975), *aff'd.*, 423 U.S. 975 (1975).

508. The court stated that "it has been held permissible for agencies of the federal government to contract with private organizations in order to have such organizations perform governmental functions as long as the particular administrative scheme provides for a hearing on the determinations made by those private organizations." See *State of Texas v. National Bank of Commerce*, 290 F.2d 229 (5th Cir.), *cert. denied*, 368 U.S. 832 (1961); *Coral Gables Convalescent Home, Inc. v. Richardson*, 340 F. Supp. 646 (S.D. Fla. 1972).

509. 422 U.S. 749 (1975).

510. See Goldstein, *The Procedural Impact of Weinberger v. Salfi Revisited*, 31 DEPAUL L. REV. 721 (1982) (focusing upon procedural aspects relevant to federal litigation affecting benefits or beneficiaries in Social Security program); Comment, *Fed-*

Both beneficiaries and providers have sought to obtain judicial review of coverage and payment determinations under the Medicare program through means other than the statutory grants of judicial review in the Social Security Act and, specifically, to circumvent the bar to federal question jurisdiction in section 205(h). Claimants have used two approaches to establish federal jurisdiction for judicial review. These include an implied grant of jurisdiction under section 10 of the Administrative Procedure Act,⁵¹¹ and an action in the United States Court of Claims under the jurisdictional grant of the Tucker Act.⁵¹² The Supreme Court has rejected both of these approaches.⁵¹³

Claimants have also sought to mitigate the harsh consequences of the jurisdictional bar in section 205(h) by invoking the All Writs Act under 28 U.S.C. section 1651,⁵¹⁴ which establishes limited federal jurisdiction in Medicare cases.⁵¹⁵ In *V.N.A. of Greater Tift County, Inc. v. Heckler*,⁵¹⁶ the Eleventh Circuit, relying on *Federal Trade Commission v. Deans Foods Co.*,⁵¹⁷ recognized federal jurisdiction under the All Writs Act, despite the jurisdictional bar in section 205(h), in order to stay the agency's enforcement of its decision and preserve the status quo pending the court's review through prescribed channels. In addition, claimants have sought to use mandamus as a means of compelling agency action in Medicare cases, irrespective of the jurisdictional bar in section 205(h). This approach has received limited success.⁵¹⁸

eral Question Jurisdiction over Medicare Provider Appeals After Weinberger v. Salfi: Toward a Principled Construction of the Statutory Bar, 65 VA. L. REV. 1383 (1979) (discussing refusal of federal courts of appeals to assume federal question jurisdiction over provider claimants who have sought higher reimbursement or equitable relief in federal courts).

511. 5 U.S.C. §§ 701-706 (Supp. III 1985).

512. 28 U.S.C. § 1491 (Supp. III 1985).

513. See *Whitecliff, Inc. v. United States*, 536 F.2d 347 (2d Cir. 1976), *cert. denied*, 430 U.S. 969 (1977) (relying on 28 U.S.C. § 1491 (1982 & Supp. II 1984)).

514. 28 U.S.C. § 1651 (1982 & Supp. II 1984). The All Writs Act provides in pertinent part: "The Supreme Court and all Courts established by Act of Congress may issue all writs necessary or appropriate in aid of their respective jurisdiction and agreeable to the usages and principles of law." *Id.* § 1651(a).

515. See, e.g., *Redbud Community Hosp. Dist. v. Heckler*, [1984-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,085 (N.D. Cal. July 30, 1984); *Alabama Home Health Care, Inc. v. Schweiker*, 527 F. Supp. 849 (N.D. Ala. 1981), *dismissed and vacated*, 711 F.2d 988 (11th Cir. 1983). *But see Florida Medical Ass'n v. HEW*, 601 F.2d 199 (5th Cir. 1979), *vacating injunction issued in*, 454 F. Supp. 326 (M.D. Fla. 1978).

516. 711 F.2d 1020 (11th Cir. 1983), *cert. denied*, 466 U.S. 936 (1984).

517. 384 U.S. 597 (1966).

518. See, e.g., *Dietsch v. Schweiker*, 700 F.2d 865 (2d Cir. 1983) (allowing mandamus jurisdiction to review procedural dispute unrelated to merits of claim for benefits); *Martinez v. Bowen* [1987-1] Transfer Binder] Medicare and Medicaid Guide (CCH) ¶

The Supreme Court considered the application of the jurisdictional bar in section 205(h) in a suit brought by four beneficiaries challenging HCFA's policy that carotid body rejection as a means of relieving pulmonary distress was not a covered benefit under the Medicare program as interpreted in HCFAR-80-1.⁵¹⁹ ALJ's had consistently ruled in favor of claimants in coverage disputes over this procedure. Plaintiffs alleged that since they were challenging HCFA's coverage policy, rather than just a determination on a claim, they were entitled to proceed directly to federal court without having an administrative hearing. The Supreme Court rejected this argument and, reaffirming its position in *Weinberger v. Salfi*,⁵²⁰ ruled that the bar to federal question jurisdiction in section 205(h) includes beneficiary disputes over coverage. Thus, beneficiaries had to exhaust their administrative remedies under section 205(b) before proceeding to federal court.

The Supreme Court's recent decision in *Bowen v. Michigan Academy of Family Physicians*,⁵²¹ however, wrought a significant erosion of the section 205(h) jurisdictional bar. In this case, an association of

35,940 (D.N.M. Oct. 14, 1986) (mandamus jurisdiction allowed to enforce prior court order requiring predetermination hearing before denial of certain home health benefits); *Samaritan Health Center v. Heckler, Medicare & Medicaid Guide (CCH)* ¶ 34,862 (D.D.C. Aug. 29, 1985) (allowing mandamus jurisdiction to review Secretary's failure to promulgate regulations allegedly required by statute where plaintiff's claim for payment under Medicare would remain to be adjudicated in administrative process); *McCuin v. Heckler, Medicare & Medicaid Guide (CCH)* ¶ 34,528 (D.N.H. Feb. 27, 1985) (holding that section 405(h) does not bar mandamus jurisdiction); *Jameson v. Heckler, [1984-1985 Transfer Binder] Medicare & Medicaid Guide (CCH)* ¶ 34,534 (E.D. Cal. Feb. 15, 1985) (noting court has mandamus jurisdiction to review constitutional challenge to HHS procedures governing payment of Medicare Part B claims); *David v. Heckler* 591 F.2d 1033, 1041-44 (S.D.N.Y. 1984) (allowing mandamus jurisdiction to review constitutionality of HHS claims review procedure); *Soberal-Perez v. Schweiker*, 549 F. Supp. 1164 (E.D.N.Y. 1982) (finding mandamus jurisdiction available to review constitutional claim seeking to require Secretary to provide Social Security notices in Spanish), *aff'd*, 717 F.2d 36 (2d Cir. 1983), *cert denied*, 466 U.S. 929 (1984). *But see* *Good Samaritan Medical Center v. Secretary of HHS*, 776 F.2d 594 (6th Cir. 1985) (declining federal question jurisdiction under 28 U.S.C. § 1331 (1982) to hear due process challenges to Secretary's decision concerning whether certain items were eligible for Medicare Part B payments); *American Fed'n of Home Health Agencies, Inc. v. Heckler*, 754 F.2d 896 (11th Cir. 1985) (interpreting section 405(h) to bar federal question jurisdiction over challenge to Secretary's modification of provider reimbursement process); *Starnes v. Schweiker*, 748 F.2d 217 (4th Cir. 1984) (finding procedural challenge so inextricably intertwined with claim for benefits that district court lacked both federal question and mandamus jurisdiction), *cert. denied*, 471 U.S. 1017 (1985) (denying mandamus). In *Heckler v. Ringer*, the Supreme Court declined to decide the effect of section 405(h) on the availability of mandamus jurisdiction in Social Security cases. 466 U.S. at 616.

519. HCFAR-80-2, Medicare Program, *Exclusion of Bilateral Carotid Body Rejection to Relieve Pulmonary Distress*, 45 Fed. Reg. 71,426 (1980).

520. 422 U.S. 749 (1975).

521. 106 S. Ct. 2133 (1986).

family physicians and several individual physicians challenged Medicare regulations permitting different levels of payment to general practitioners and specialists for the same services. A unanimous Court⁵²² recognized a right of judicial review for challenges to regulations establishing the methodology to be used to set payment rates under Part B, despite the statutory preclusion of judicial review of Part B claims in section 1869⁵²³ and the jurisdictional bar in section 205(h).

Reviewing its earlier decisions that had maintained a strong presumption in favor of judicial review of administrative action,⁵²⁴ the Court concluded that section 1842(b)(3)(C)⁵²⁵ “simply does not speak to challenges mounted against the *method* by which such amounts are to be determined rather than the *determinations* themselves” (emphasis in original).⁵²⁶ The Supreme Court emphasized that the statutory preclusion of federal jurisdiction and judicial review in these cases pertained to disputes over the amount of benefits.⁵²⁷

This is an extremely important decision for the entire Medicare appeals system. It addresses one of the most widespread and strongest concerns among beneficiaries and providers under both Part A and Part B — the inability to challenge HHS regulations, rulings, and program directives governing a coverage or payment claim except where expressly permitted under the Social Security Act. The implications of this case for the Medicare appeals system have yet to unfold, although it is fair to say that this decision will open the gates for future court challenges to HHS regulations. Moreover, policies and directives governing all aspects of the Medicare program may be subject to judicial appeal without the necessity of exhausting administrative remedies.

522. Mr. Justice Rehnquist, who wrote the majority opinion in *Heckler v. Ringer*, did not participate in this decision.

523. Social Security Act, § 1869, 42 U.S.C. § 1395ii (1982 & Supp. II 1984).

524. See, e.g., *Stark v. Wickard*, 321 U.S. 288 (1944); *Abbott Laboratories v. Gardner*, 387 U.S. 136 (1967); *Barlow v. Collins*, 397 U.S. 159 (1970); *Dunlop v. Bachowski*, 421 U.S. 560 (1975).

525. Social Security Act, 42 U.S.C. §§ 1395ff(b)(1)(C), 1395u(b)(3)(C) (1982 & Supp. III 1985).

526. *Bowen v. Michigan Academy of Family Physicians*, 106 S. Ct. at 2138. The Court then stated:

We conclude, therefore, that those matters which Congress did *not* leave to be determined in a “fair hearing” conducted by the carrier — including challenges to the validity of the Secretary’s instructions and regulations — are not impliedly insulated from judicial review by 42 U.S.C. § 1395ff.

527. *Id.* at 2140 (emphasis in original). Clarifying its position in *Salfi*, *Ringer*, and *Erika*, the Court stated that “matters which Congress did *not* delegate to private carrier, such as challenges to the validity of the Secretary’s instructions and regulations are cognizable in courts of law.” *Id.* (emphasis in original).

Since *Michigan Academy of Family Physicians*,⁵²⁸ several courts have recognized federal question jurisdiction under section 1331⁵²⁹ where it is clear the disputes over the amount of payment were not at issue. In *Linoz v. Heckler*,⁵³⁰ the Ninth Circuit recognized jurisdiction in challenges to program instructions defining coverage of specific health care services. Further, in *Medical Fund - Philadelphia Geriatric Center v. Heckler*⁵³¹ the court overturned the dismissal of a challenge by physicians to a payment policy under Part B on jurisdictional grounds. However, some courts have been more circumspect about granting federal question jurisdiction before claimants have exhausted extant administrative proceedings in which the claimants' challenges could be effectively raised.⁵³²

In the Omnibus Budget Reconciliation Act of 1986, Congress sought to curtail the availability of judicial review for national coverage determinations and Part B payment methodologies adopted before 1981, and thus to mitigate the potential flood of challenges to Part B coverage and payment policies made possible by the Supreme Court's recognition of federal question jurisdiction in *Michigan Academy of Family Physicians*. In so doing, Congress, through the vehicle of a statutory preclusion of judicial review, has sharply curtailed the usefulness of *Michigan Academy of Family Physicians* in challenging HCFA coverage and payment policies under Part B.

VII. PROPOSED RECOMMENDATIONS AND SUGGESTIONS FOR FURTHER STUDY

This chapter outlines some proposed recommendations for improvements in the Medicare appeals system. In addition, this chapter also indicates where more information is needed and further study is appropriate before definitive recommendations can be offered. It is important to remember the financial constraints on HHS and HCFA in administering the Medicare program. Indeed, in recent years this pressure to contain the escalating costs of the Medicare program, which constituted 7% of the federal budget in 1986,⁵³³ has been especially acute in view of the drastically expanding federal budget deficit.⁵³⁴ Thus, in propos-

528. 422 U.S. 749 (1975).

529. 28 U.S.C. § 1331 (1982).

530. 800 F.2d 871 (9th Cir. 1986).

531. 804 F.2d 33 (3rd Cir. 1986).

532. See, e.g., *Buckner v. Heckler*, 804 F.2d 258 (4th Cir. 1986); *Frankford Hospital v. Davis*, 647 F. Supp. 1433 (E.D. Pa. 1986).

533. See BUDGET OF THE UNITED STATES, FY 1987 *supra* note 13.

534. The federal budget deficit has grown dramatically since 1981. The deficit for

ing changes in the Medicare appeals system, it is necessary to assess the cost of the proposed change against the benefit to be derived. Some changes in the Medicare appeals system would clearly make for a more fair appeals system. However, such changes may be unduly costly, benefiting only a few individuals or benefiting many in a minimal way, and thus not being justifiable.

A. Program Administration Issues

This article has identified three problem areas in the administration of the Medicare program: (1) intermediary and carrier coverage and payment determinations; (2) the setting of prices under the prospective payment system; and (3) implementation of the PRO program. With respect to these areas, recommendations for changes are appropriate and further study is clearly needed.

1. Intermediary and Carrier Coverage and Payment Determinations

The performance of fiscal intermediaries and carriers in making coverage and payment determinations has been controversial. Carriers and fiscal intermediaries, often at HCFA's direction, have engaged in disturbing practices when making coverage and payment determinations under the Medicare program. This is a significant concern because these practices often result in unwarranted financial liability for beneficiaries. These practices include the following: (1) the use of unpublished guidelines and standards in making coverage determinations; (2) a systematic interpretation of statutory language to define benefits in a manner that effectively reduces benefits under the Medicare program; and (3) the communication with beneficiaries regarding coverage and payment determinations and appeal rights in an incomprehensible fashion, thereby inhibiting appeals of these determinations.

The problems raised in this article have been reported in congressional hearings or challenged in litigation. Their existence suggests that problems with other coverage and payment determination procedures may exist and may also compromise the interests of Medicare beneficiaries. The performance of fiscal intermediaries and carriers in making coverage and payment determinations and the wide specter of problems in this area pose critical issues for the Medicare program. Two key elements are: (1) the appropriateness of delegating these major pro-

the Fiscal Years 1981 through 1985 are as follows: FY 1981 - \$78.0 billion; FY 1982 - \$127.9 billion; FY 1983 - \$207.7 billion; FY 1984 - \$185.3 billion; FY 1985 - \$212.3 billion. BUDGET OF THE UNITED STATES, FY 1987, *supra* note 13.

gram functions to private organizations; and (2) the adequacy of current procedures to protect beneficiaries' entitlement interests in Medicare benefits under this administrative arrangement.

Clearly, more information is needed about how fiscal intermediaries and carriers make coverage and payment determinations and how they handle beneficiary complaints regarding these determinations. Several problems with coverage and payment determinations also need particular attention. These include the following: (1) the process for determining the reasonable charge for physicians' services under Part B; (2) HCFA's technical denials policy with respect to home health benefits and the implementation of this policy by fiscal intermediaries;⁵³⁵ and (3) whether the problems in communications between fiscal intermediaries and between carriers and beneficiaries regarding coverage and payment decisions have been adequately addressed as a result of reforms mandated in the *Gray Panthers* litigation.⁵³⁶ In view of these problems and their importance to the overall integrity of the Medicare program, a comprehensive, empirical study to obtain information about the coverage and payment determination procedures of fiscal intermediaries and carriers should be conducted.

Another issue deserving additional analysis is the use of statistical sampling to project overpayments to providers pursuant to HCFAR-86-1.⁵³⁷ This approach to calculating overpayments to providers may well be justified, although such an approach should be made pursuant to explicit statutory authority that carefully delineates the circumstances in which it may be used. Further, there is question as to why current Medicare fraud and abuse statutes, such as the Civil Monetary Penalties Act,⁵³⁸ are not sufficient to address the type of systematic overbilling that HCFAR-86-1 attempts to correct.

Recommendations

First, HCFA should publish and make available, upon request, to beneficiaries and providers all standards and guidelines used in making coverage and payment determinations under Part A and Part B. Sec-

535. See *supra* notes 345-46 and accompanying text (discussing conditions for items and services to be considered home health services).

536. See *supra* notes 362-77 and accompanying text (discussing need for information transmitted to beneficiaries to be comprehensible).

537. See *supra* notes 350-55 and accompanying text (discussing HCFA's approval of using statistical samplings when case-by-case approach review is not feasible).

538. Social Security Act, § 1128A, 42 U.S.C. § 1320a-7a (1982 & Supp. III 1985); 42 C.F.R. §§ 1003.100-1003.133 (1986) (regulations implementing Civil Monetary Penalties Act of 1981).

ond, Congress or HHS should prohibit fiscal intermediaries and carriers from using practices of the insurance industry, i.e., "rules of thumb" or screens, that are not published in regulations or program instructions in making coverage and payment determinations under Part A and Part B. Third, HCFA should ensure that program instructions containing important and substantive interpretations of Medicare coverage and benefits are promulgated according to informal rulemaking procedures or through procedures that ensure that the medical profession, beneficiaries, and other interested parties have an opportunity to comment on the medical and other significant implications of HCFA's interpretation and coverage of these benefits.

Suggestions for Further Study

First, a comprehensive, empirical study should be conducted of the role, performance, and procedures of fiscal intermediaries and carriers in making coverage and payment determinations under Part A and Part B. Second, a study of procedures for making coverage and payment determinations for home health benefits should be conducted, with specific examination of HCFA's use of statistical sampling to project overpayments to providers pursuant to HCFAR-86-1.

2. Setting the Price Under the Prospective Payment System

Congress, ProPAC, and hospitals have expressed concern that HHS's primary motivation is to reduce the Medicare budget in setting and updating hospital payment rates under the prospective payment system. A key question is whether the current administrative arrangement adequately protects hospitals from arbitrary HHS action in setting these rates. Under the current administrative arrangement, hospitals are expressly precluded from challenging DRG's or their derivation through administrative or judicial review. This begs the question of whether the informal rulemaking process that HHS must follow in updating hospital payment rates and ProPAC's role in independently analyzing and commenting on HHS's performance are sufficient to protect individual hospitals' interests in fair and adequate payment rates. Further, are these procedures sufficient to mitigate the need for administrative and judicial review?

This issue requires additional analysis before definitive recommendations are appropriate. Hospitals are doing well financially under the prospective payment system, an important fact to consider in assessing hospitals' concerns about deficiencies in appeals procedures for hospital

payment. ProPAC and Congress, however, have criticized HHS's method of updating hospital payment rates under the prospective payment system. The resolution of this issue may require more experience with the prospective payment system to determine whether the administrative arrangement works in the manner Congress originally contemplated and protects the legitimate interests of hospitals in setting fair Medicare payment rates.

Suggestions for Further Study

An analysis should be conducted of whether the current administrative arrangement for updating hospital payment rates under the prospective payment system is adequate to protect individual hospitals' interests in fair payment rates, while giving HHS sufficient flexibility to achieve necessary budget savings.

3. Implementation of the Peer Review Program

In *American Hospital Association v. Bowen*,⁵³⁹ hospitals successfully challenged HCFA's implementation of the PRO program through program instructions and contract provisions that had not been promulgated as rules under the Administrative Procedure Act. The PRO program is a major program with the critical function of monitoring hospital conduct toward individual beneficiaries and the quality of hospital care under the prospective payment system. Consequently, the confusion generated by this decision should be resolved as soon as possible.

Recommendations

HHS should promulgate an interim final rule to implement the PRO program in the manner indicated in *American Hospital Association v. Bowen*. This rule should address matters now covered in program instructions and PRO contract provisions.

B. Administrative Hearing Issues

This article has identified a number of problem areas regarding administrative hearing procedures for coverage and payment determinations under Part A and Part B of the Medicare program. These include: (1) beneficiary coverage appeals under Part A; (2) provider

539. 640 F. Supp. 453 (D.D.C. 1986); see *supra* notes 393-97 and accompanying text (discussing procedural history of *American Hospital Association*).

disputes under Part A; and (3) hearing procedures for beneficiaries and providers under Part B.

1. *Beneficiary Appeals Under Part A*

There are three areas of particular concern regarding beneficiary coverage appeals under Part A:⁵⁴⁰ (1) appeals under the prospective payment system; (2) provider representation of beneficiaries in Part A appeals;⁵⁴¹ and (3) deficiencies in appeals procedures for claims under \$100.⁵⁴² With respect to beneficiary appeals procedures under the prospective payment system, the most serious problem has been adequately informing beneficiaries of their appeal rights. This problem has been especially evident with respect to hospital and/or PRO decisions that continued stay of a beneficiary in the hospital is no longer necessary. HCFA, Congress, and ProPAC are aware of this problem and have adopted measures to address it.⁵⁴³ Recommendations should thus be deferred and further monitoring undertaken to ascertain if these measures have resolved this problem.

The role and responsibility of PRO's in adjudicating appeals over coverage and payment determinations under the prospective payment system for both beneficiaries and hospitals has generated the question whether PRO's fully appreciate and understand their adjudicative responsibilities for beneficiary coverage determinations and certain payment issues for hospitals under the prospective payment system.⁵⁴⁴ An empirical study should be conducted to obtain more information about PRO performance in discharging these responsibilities. Specifically, a study should ascertain whether PRO's fully understand their adjudicative responsibilities and whether they have adopted standards and

540. With regard to administrative hearings before ALJ's and the SSA Appeals Council, no recommendations or suggestions for further study are made since the concerns of Medicare beneficiaries are similar to those of other Social Security programs, and the American Bar Association, with the involvement of the Administrative Conference of the United States, has addressed these hearing procedures and made recommendations in another context.

541. In the Omnibus Budget Reconciliation Act of 1986, Congress specifically overruled HCFA's policy of limiting provider representation of beneficiaries.

542. As for hearing procedures for claims under \$100, the United States District Court for the District of Columbia in the *Gray Panthers* litigation ruled that expanded hearing procedures for these claims is not required since there are less than 100 such claims annually. This conclusion is eminently reasonable given the current financial constraints of the Medicare program. See *supra* notes 418-22 and accompanying text (discussing history of *Gray Panthers* litigation).

543. See *supra* notes 403-13 and accompanying text (assessing information to beneficiaries regarding appeals rights).

544. See *supra* notes 414-17 and accompanying text (discussing PRO appeals procedures).

guidelines to conduct the adjudications assigned to them.

Suggestions for Further Study

A comprehensive, empirical study should be conducted of the performance by PRO's of their adjudicative responsibilities with respect to appeals of beneficiaries and hospitals under the prospective payment system.

2. Provider Payment Disputes Under Part A

There are four problem areas with respect to provider disputes under Part A: (1) jurisdiction of the PRRB for hospital appeals under the prospective payment system; (2) retrospective correction of errors in payment rates; (3) HHS nonacquiescence with judicial decisions; and (4) the PRRB's role and procedures. Since the inception of the Medicare program, HHS has taken a very tough stance in provider challenges to payment levels under Part A. As guardian of the Medicare trust funds, and especially considering current budget pressures, this position is clearly appropriate.

At some point, however, a question of fairness is raised. This point may have been reached with respect to some Medicare payment issues in view of the fact that federal district and appellate courts have almost uniformly rejected these policies. HHS should reevaluate these payment policies in light of these judicial decisions. HHS has not, however, adopted this approach and has often refused to follow adverse court decisions on Medicare payment policies in a rather troubling policy of frank non-acquiescence.⁵⁴⁵ In light of recent judicial decisions, some recommendations are appropriate and further study warranted.

Recommendations

First, HCFA should repeal HCFAR-84-1⁵⁴⁶ and interpret the language in section 1878(a) ("final determination of the Secretary as to the amount of payment")⁵⁴⁷ to mean the fiscal intermediary's final determination of the prospective payment rate for the upcoming fiscal year as construed in *Washington Hospital Center v. Bowen*.⁵⁴⁸ Second,

545. See *supra* notes 443-50 and accompanying text (noting HHS's history of non-acquiescence with judicial decisions).

546. 49 Fed. Reg. 2241 (1984).

547. Social Security Act, § 1878(a), 42 U.S.C. § 1395(a) (1982 & Supp. III 1985).

548. See *supra* notes 437-42 and accompanying text (discussing eliminating requirement that PPS recipients file cost report before appealing).

HCFA should revise its regulations⁵⁴⁹ to allow retroactive correction of errors in the calculation of a hospital's base year for purposes of calculating hospital payment rates under the prospective payment system during the transition period.⁵⁵⁰ Third, HHS should develop a principled policy on when it will acquiesce to judicial decisions affecting the Medicare program and all other programs under the Social Security Act.

Suggestions for Further Study

An analysis should be conducted of the future role of the PRRB. The study should determine whether the PRRB should function as an independent tribunal and what specific responsibilities it should assume.

3. Hearing Procedures Under Part B

The specific character of the procedures for Part B hearings for all coverage and payment determinations has been addressed in *Gray Panthers* and other recent litigation. HCFA has adopted changes to implement some of the concerns over Part B hearing procedures raised in those cases.⁵⁵¹ Further, in the Omnibus Budget Reconciliation Act of 1986, Congress established administrative review for sizeable Part B claims within the federal government. HHS is now charged with the responsibility of designing an administrative review system for Part B claims.

Recommendations

HCFA should establish an administrative review process with ALJ's that is accessible to all beneficiaries and providers under the Medicare program.

C. Availability of Administrative and Judicial Review

Of all legal issues confronting the Medicare appeals system, the statutory preclusion of administrative and judicial review of certain coverage and payment determinations is the greatest concern of beneficiaries and providers. Congress, until 1986, had precluded administrative and judicial review for coverage and payment determinations under Part B.

549. 42 C.F.R. § 412.72 (1986).

550. See *supra* notes 437-42 and accompanying text (noting provisions for retropective correction of errors in prospective payments rates).

551. See *supra* notes 463-75 and accompanying text (noting due process challenges to hearing procedures under Part B).

Congress had maintained the preclusion for certain payment issues under Part A's prospective payment system for hospitals. Beneficiaries and providers are also concerned that the operation of section 205(h) of the Social Security Act⁵⁵² precludes federal question jurisdiction for cases involving claims for payment, except when the Social Security Act explicitly authorizes judicial review.

1. Preclusion of Administrative and Judicial Review of Part B Claims

Congress has now authorized administrative and judicial review of coverage and payment determinations under Part B. But in so doing, Congress put some important limitations on the opportunity for administrative and judicial review of HCFA's national coverage determinations and pre-1981 payment policies for Part B.

Recommendations

Congress should examine whether its limitation on administrative and judicial review of national coverage determinations is warranted.

2. Preclusion of Administrative and Judicial Review of Certain Hospital Payment Issues

The preclusion of administrative and judicial review with respect to certain payment issues, i.e., matters related to determining the DRG's, under the prospective payment system is unusual. However, these statutory preclusions may well be desirable because of the clear need to preserve the integrity of the prospective payment system's rate structure. The central question is whether Congress has designed the rate-setting process in such a way that will ensure that hospitals are fairly compensated for the services they provide to Medicare beneficiaries. This question warrants further examination.

3. Jurisdictional Bar to Judicial Review Under the Social Security Act

One of the most intractable problems for beneficiaries and providers under the Medicare program has been the bar to federal question jurisdiction in section 205(h) of the Social Security Act. Especially troublesome is its application in light of *Weinberger v. Salfi* and *Heckler v.*

552. Social Security Act, § 205(h), 42 U.S.C. § 405(h) (1982 & Supp. III 1985).

Ringer, which prevents beneficiaries and providers from challenging provisions and policies related to coverage and payment determinations without first exhausting all administrative remedies.⁵⁵³ However, this concern may well be mitigated by the Supreme Court's recent decision in *Bowen v. Michigan Academy of Family Physicians*, which granted federal question jurisdiction without exhaustion of administrative remedies to a challenge of the methodology for setting a payment rate rather than the amount of payment in a claim.⁵⁵⁴ This case may well change the entire complexion of jurisdictional issues under the Social Security Act. Consequently, recommendations and further study should be deferred until courts have interpreted this decision in other contexts and reconciled it with the Supreme Court's earlier decision in *Heckler v. Ringer*.

D. Proposal for a Conference on the Medicare Appeals System

Because of the complexity of the Medicare program, the prospect of additional and ongoing changes in the program, and the volume of concerns and complaints from beneficiaries and providers about all aspects of the Medicare appeals system, it is recommended that a conference on the Medicare appeals system be convened. A conference would gather substantial information about and analysis of problems with the Medicare appeals system, as well as generate ideas for future recommendations for reforms. This conference should convene experts from HHS, HCFA, ProPAC, congressional staff, beneficiary and provider groups, leading practitioners, and scholars to analyze the problems with the Medicare appeals system, make recommendations for specific reforms, or even consider a major restructuring of the Medicare appeals system. The following is a list of issues that should be addressed at the conference.

1. Program Administration Issues

First, what is the appropriate role of fiscal intermediaries, carriers, and PRO's in making coverage and payment determinations and in performing other administrative functions under the Medicare program? Second, are the procedures used by fiscal intermediaries, carriers, and PRO's in making coverage and payment decisions in individual

553. See *supra* notes 509-27 and accompanying text (discussing requirements of exhausting all administrative remedies as jurisdictional bar to judicial review).

554. See *supra* notes 498-99 and accompanying text (discussing availability of judicial review of methodology used in making determinations).

cases fair and adequate? Third, is the current administrative arrangement for updating hospital payment rates under the prospective payment system adequate to protect individual hospitals' interests in fair payment rates, while at the same time giving HHS sufficient flexibility to achieve necessary budget savings? Fourth, is the process that HCFA uses to make decisions under Part A and Part B as to whether new procedures and technologies are covered Medicare benefits fair to beneficiaries, providers, and other affected groups?

2. Administrative Hearing Issues

First, are the procedures for adjudicating coverage and payment disputes under Part B adequate to protect the interests of beneficiaries and providers in view of continuing changes in the nature and amount of benefits under Part B? Second, what is the legitimate interest of providers in coverage determinations, and what rights of appeal should be available for providers to protect this interest? Third, should there be a Medicare appeals division in HCFA with ALJ's to adjudicate coverage and payment disputes of beneficiaries under Part A and Part B, and if so, how should such a division be structured? Fourth, what should be the future role of the PRRB? Should it be an independent tribunal, and what specific adjudicative responsibilities should it assume?

3. Availability of Administrative and Judicial Review

First, are the limitations on administrative and judicial review of national coverage determinations and Part B payment methodologies appropriate? Second, does the current administrative arrangement for updating hospital payment rates under the prospective payment system provide enough protection to the interests of individual hospitals in a fair payment rate to justify the preclusion of administrative and judicial review of major payment issues?

CONCLUSION

The Medicare appeals system is a complex system that has been called upon to deal with the challenges posed by great changes in the Medicare program and the American health care system in recent years. Despite these changes, there has not been a comprehensive study of how the Medicare appeals system should be structured to meet these challenges and ensure that beneficiaries and providers of the Medicare program are treated fairly. In view of the restructuring of the hospital

payment system in 1983 and the contemplated changes in Part B of the Medicare program, it is now especially appropriate to reexamine whether the appeals system designed and implemented in the late 1960's and early 1970's can meet the challenges posed by a significantly different health care system and Medicare program. This article is a first step in such an endeavor.⁵⁵⁵

555. On December 6, 1986, the Plenary Session of the Administrative Conference of the United States adopted several recommendations for reforms of the Medicare appeals system. Recommendation 86-5, 1 C.F.R. § 305.86-5 (1987). There are three areas for these recommendations: (1) publication of policies; (2) administrative appeal procedures; and (3) suggestions for further study. In addition, the ABA Commission on Legal Problems of the Elderly and the Administrative Conference of the United States convened a conference on Medicare appeals issues in October 1987.